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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2TOD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00332

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245580**

2.STATE VENDOR OR MEDICAID NO.
(L2) **911243000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKEWOOD CARE CENTER**
(L4) **600 MAIN AVENUE SOUTH**
(L5) **BAUDETTE, MN** (L6) **56623**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/14/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **36** (L18)

13.Total Certified Beds **36** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 12/7/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kami Fiske-Downing, Enforcement Specialist 12/07/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245580

December 7, 2018

Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN 56623

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 October 3, 2018 the above facility is certified for:

36 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 36 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
Licensing and Certification Program
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
December 7, 2018

Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN 56623

RE: Project Numbers S5580029, F5580027, F5580030

Dear Administrator:

On August 10, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 26, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 11, 2018 a survey team representing the office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey of your facility. As the survey team informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 25, 2018, CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 26, 2018.

In addition, CMS notified you in their letter of September 25, 2018, in accordance with Federal law, as specified in the ACT at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 26, 2018.

On September 14, 2018, the Minnesota Department of Health and on November 8, 2018, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 26, 2018 and an FMS completed on September 11, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 3, 2018. Based on our Post Certification Revisits, we have determined that your facility has corrected

the deficiencies issued pursuant to the standard survey, completed on July 26, 2018 and the FMS completed on September 11, 2018, effective October 3, 2018.

As a result of the revisit findings, this Department recommended to CMS Region V Office the following actions related to the remedies in their letter of September 25, 2018. CMS Concurs and has authorized this Department to notify you of these actions:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 26, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions effective October 26, 2018 is to be rescinded. They will also notify the State Medicaid Agency that deny payment for new Medicaid admissions effective October 26, 2018 is to be rescinded.

In the CMS letter of September 25, 2018, you were advised that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 26, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 3, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2TOD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00332

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(L1) **245580**

2.STATE VENDOR OR MEDICAID NO.
(L2) **911243000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKEWOOD CARE CENTER**
(L4) **600 MAIN AVENUE SOUTH**
(L5) **BAUDETTE, MN** (L6) **56623**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/26/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **36** (L18)
13.Total Certified Beds **36** (L17)

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	36			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Vienna Anderesen, HFE - NE II 08/23/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/17/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 10, 2018

Mr. Jeffry Stampohar, Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN 56623

RE: Project Number S5580029

Dear Mr. Stampohar:

On July 26, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

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 September 4, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 4, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 26, 2018 (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 January 26, 2019 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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
	245580	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	600 MAIN AVENUE SOUTH BAUDETTE, MN 56623

(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 A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted from 7/23/18, through 7/26/18, during a recertification survey. The agency is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On July 23, 2018, through July 26, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and	F 550		9/4/18

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

Electronically Signed | 08/17/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	600 MAIN AVENUE SOUTH BAUDETTE, MN 56623

(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 550	Continued From page 1 outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents were	F 550	Lakewood updated care plan of resident to include covering R7's urinary collection	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	600 MAIN AVENUE SOUTH BAUDETTE, MN 56623

(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 550	Continued From page 2 provided care in a dignified manner for 1 of 1 resident (R7) reviewed who had an indwelling Foley catheter. Findings include: On 7/23/18, at 2:54 p.m. R7's room door was noted to be wide open. From the hallway, R7 was observed lying in bed with an uncovered urinary drainage bag hanging from the bed frame. The drainage bag contained urine and was visible to all who passed by. On 7/25/18, during random observations conducted between 7:10 a.m. and 9:27 a.m., from the doorway, R7 was observed lying in bed with an uncovered urinary drainage bag which contained urine, hanging from the bed frame. R7's door was wide open as staff and visitors passed by. On 7/26/18, at 1:02 p.m. the director of nursing (DON) verified R7's urinary catheter bag was hanging on the bed frame, uncovered, and with urine in it. The DON also confirmed R7's door was open with the drainage bag visible to all who passed by the room. The DON stated the facility did not use any type of concealing covering for the urinary drainage bags in order to maintain patient dignity. The Catheter Maintenance policy provided by the facility did not address the covering of urinary catheter bags to provide/promote resident dignity.	F 550	bag with a dignity bag at all times when cares are not being performed. Lakewood will update the catheter maintenance to include language addressing use of dignity bags over urinary collection bags. Lakewood updated dignity policy with specific language addressing use of dignity bags over urinary collection bags. The policies will be updated, and education will be provided to the care center nursing staff by DON by September 4th, 2018. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. The care center staff will audit any residents with urinary collection bags to ensure they are covered with dignity bags and that their care plan is updated. Audits will be completed 5 days a week for 2 weeks, weekly for 2 weeks, and biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality.	F 583		9/4/18

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	245580	A. BUILDING _____ B. WING _____	07/26/2018

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F 583	Continued From page 3 The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure confidential information was not readily available for all residents, staff and visitors to view for 1 of 1 resident (R7) observed to have personal care	F 583	Lakewood removed the catheter care sign on 7/26/18 from R7□s room. The DON audited all resident rooms to ensure there was no personal care information posted on room walls. Lakewood will	

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F 583	Continued From page 4 information posted in their room. Findings include: R7's quarterly Minimum Data Set (MDS) dated 7/11/18, indicated R7 had diagnoses including transient ischemic attack (TIA) and unspecified kidney failure. The MDS also indicated R7 had intact cognition, was totally dependent on staff for activities of daily living (ADL's), and had an indwelling urinary catheter. On 7/23/18, at 2:54 p.m. an 8 x 11 piece of paper was observed posted on R7's wall, above the head of bed, which read "Catheter: Ensure there is slack on catheter tubing at all times. Tubing must be secured with a leg strap at all times. Be careful with cares. Do not pull on catheter." On 7/26/18, at 1:02 p.m. the director of nursing (DON) stated she was not aware of confidential care information having been posted on R7's wall and would immediately remove it. The DON verified personal resident care information should not be posted in areas that was readily visible to others.	F 583	review privacy policy with the care center nursing staff by LSW by September 4th 2018. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. The care center staff will audit 30% of resident rooms to ensure there are no personal resident care information signs posted on room walls. Audits will be completed 5 days a week for 2 weeks, weekly for 2 weeks, and biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.	
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to	F 584		9/4/18

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F 584	Continued From page 5 use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide timely follow up regarding a missing personal item for 1 of 1 resident (R2) who reported missing a pearl ring. Findings include:	F 584	Lakewood met with R2 to discuss replacement of lost ring. Lakewood, with R2□s permission, ordered a ring that R2 picked out, to replace lost item. Lakewood will continue ask residents if they are missing items at all care conferences for each resident and at each resident council	

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F 584	Continued From page 6 R2's admission Minimum Data Set (MDS) dated 3/14/18, indicated R2 was cognitively intact and had diagnoses which included depression and weakness. On 7/25/18, at 1:15 p.m. R2 stated she was missing a pearl ring. R2 stated she thought she had put it in a plastic cup, in her room, and had put something else on top of the cup so no one would see the ring inside and believed it had been thrown away. R2 indicated this had occurred a couple of months ago. On 7/26/18, at 1:03 p.m. nursing assistant (NA)-C confirmed R2 was missing a ring which had been reported and stated the staff had been looking for it but had not found it. NA-C also stated R2 had placed the cup on a table by the garbage can but could not remember the exact details therefore the staff were not sure if it had been thrown away or not. R2's progress note dated 4/1/18, indicated R2 reported she had taken off her pearl ring and put it in a cup on the bedside table, now today could not find it. The progress note indicated R2 had changed her story several times and had reported she did not really remember where she had lost it or when it had been lost. Staff had not seen R2 wearing the ring or seen it in her room and did not recall the last time it had been seen. Housekeeping and nursing staff had searched R2's room and all personal belongings. Acute care, kitchen and laundry had also been informed of the missing item. The note indicated the facility staff would continue to monitor. On 7/26/18, at 1:46 p.m. the director of nursing (DON) provided R2's Missing Items Form dated	F 584	meeting. Lakewood will also continue to address missing items during vulnerable adult education provided to employees. Lakewood will educate staff on missing items policy specifically covering the procedure when an item is reported as missing (search for the item, if not found fill out the missing items form and turn it into Social Services and/or RN Charge, and Social Services and/or RN Charge will follow up search findings with resident within 72 hours). Lakewood will review all missing items at IDT meetings. The education will be provided to the care center nursing staff by LSW by September 4th, 2018. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. The care center staff will audit IDT meeting notes and any follow up to missing items. Audits will be completed weekly for 1 month, biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.	

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F 584	Continued From page 7	F 584		

4/1/18. The form contained two sections: Description of Missing Property and Missing Item Follow-Up. The Description of Missing Property section identified on 4/1/18, at 10:00 a.m. R2 had reported a missing pearl ring. The ring had been initially indicated as last seen on the bedside table in a medication water cup. The form indicated R2 changed her story to not remembering when the ring was last seen. The Missing Item Follow-Up section included fields for 72 hours, outcome, replaced/by whom, documentation, police report filed with date and report number, outcome of actions. The section also contained fields for found items including: where, date, found by whom, item(s) returned to, date, by, staff signature and date, social services staff signature and date. The DON confirmed all fields in the Missing Item Follow-Up section were blank and she had spoken with the licensed social worker (LSW), who was not working this week, who had indicated he had spoken with R2 about replacing the ring but R2 had not decided yet if she wished to proceed with replacement.

On 7/26/18, at 2:57 p.m. the DON and the Vice President of Patient Affairs (VP) were interviewed regarding the facility policy for the follow up of missing items. The DON confirmed it had been over three months since R2's ring had been reported missing and indicated she believed it had been LSW's plan to follow up with R2 when he returned to work. The DON did not identify a timeframe in which she would have expected follow up to occur. The VP indicated she would have expected the facility policy to be followed.

--At 3:34 p.m. R2 confirmed LSW had spoken with her about her lost ring, however, stated she did not remember what he had said. R2 indicated

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F 584	Continued From page 8 the facility had replaced a lost necklace in the recent past, however, did not remember if they had offered to replace her ring and did not know of a plan moving forward. The Missing Items policy dated 4/2018, indicated the facility would attempt to locate and return missing items in a timely manner. The policy also indicated lost items must be reported immediately to social services and would be considered for reimbursement if the resident wished.	F 584		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		9/4/18

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F 755	Continued From page 9 receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a mouth rinse was provided after the administration of medication via a dry powder inhaler as directed by the medication's manufacturer recommendations for 1 of 1 resident (R7) who received steroidal medication via a dry powder inhaler without a mouth rinse afterward. Findings include: R7's current Physician Orders provided 7/25/18, included an order dated 6/15/18, for fluticasone furoate-vilanterol (steroidal medication) aerosol powder, breath activated, 1 inhalation every morning for chronic obstructive pulmonary disease (COPD). The BREO ELLIPTA Medication Guide dated May 2017, indicated the possible side effects of the medication included fungal infection of the mouth or throat (thrush) and directed rinse mouth with water without swallowing after using BREO ELLIPTA to help reduce the chance of getting thrush. On 7/25/18, at 9:20 a.m. trained medication aid (TMA)-A was observed to approach R7 at a table in the dining room with her morning medications. TMA-A took R7's blood pressure and then handed an inhaler to R7. R7 placed the inhaler up to her mouth and inhaled the medication by	F 755	Lakewood educated TMA regarding prompting R7 and any other residents who receive steroidal medication via a dry powder inhaler to rinse mouth afterwards. Lakewood updated medication administration policy to include specific language addressing rinsing mouth after use of steroidal medication via a dry powder inhaler. It also includes language regarding additional cueing and assistance to those residents that are cognitively impaired. The policies will be updated, and education will be provided to the care center nursing staff by DON by September 4th, 2018. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. The care center staff will audit all shifts that a resident would receive an ordered steroidal medication via a dry powder inhaler to ensure the residents are cued to rinse mouth afterwards. Audits will be completed 5 days a week for 2 weeks, weekly for 2 weeks, and biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.	

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F 755	Continued From page 10 herself. TMA-A gave R7 a glass of apple juice. R7 took a sip of the apple juice which she then swallowed. TMA-A did not prompt R7 to rinse and spit after the inhalation of the medication. TMA-A proceeded to provide R7 her oral medications which she swallowed using the remainder of the apple juice. --At 9:30 a.m. TMA-A verified she should have had R7 do a swish and spit after use of the inhaler but had not done so. TMA-A verified R7 had swallowed the apple juice. --At 1:12 PM the director of nursing stated her expectation would be for staff to have provided a swish and spit after the administration of the inhaled medication as directed by the manufacturer's recommendations. The Medication Administration policy dated 7/2018, directed when administering an inhaler medication, shake the inhaler and allow 1 minute between puffs. The cognitively impaired resident may need cueing and assist when using an inhaler. The policy did not address the administration of steroid medication via dry powder inhaler.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart.	F 756		9/4/18

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F 756	Continued From page 11 §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility pharmacist failed to ensure antipsychotic medications had appropriate indications for their use for 1 of 5 residents (R8) reviewed for unnecessary medications. Findings include:	F 756	Lakewood reviewed R8□s behavior monitoring with provider on August 10th, 2018 and initiated a gradual dose reduction of the Risperdal with the intention of decreasing the dose to a point of discontinuation. A qualitative analysis of psychotic behaviors will be completed by September 4th, 2018. Lakewood will	

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F 756	Continued From page 12 R8's face sheet dated 7/26/18, indicated R8's diagnoses included major depressive disorder with psychotic features, type II diabetes, and obesity. R8's annual Minimum Data Set (MDS) dated 1/3/18, and both quarterly MDS assessments dated 3/28/18, and 6/20/18, indicated R8 had moderate cognitive impairment, had no low mood symptoms, exhibited no inappropriate behavior symptoms, had no symptoms of psychosis (hallucinations, delusions, paranoia), and had no incidence of verbal or physical abuse or rejection of care. The MDS's indicated R8 required extensive assistance of one person for dressing, toilet use, and personal hygiene. Review of R8's current physician orders (undated) indicated R8 had been receiving Risperdal 2 mg (antipsychotic medication) every evening since 2/18/14, for target behaviors of yelling, hitting staff during cares, refusing cares, swearing at staff, attempting to leave the building, wandering, and making constant requests of being hungry after eating. R8 had no target behaviors which indicated R8 had psychosis (hallucinations, delusions, paranoia) in order to justify the use of an antipsychotic medication. Review of R8's progress notes from 3/1/18-7/25/18, indicated R8 yelled out either requesting food or voiced complaints of hunger nine times, had made inappropriate sexual comments twice, and either attempted to leave the building or threatened to leave the building on five occasions. R8's progress notes reviewed had not identified any psychotic behavior (hallucination's, delusion's, or unreasonable paranoia).	F 756	present the qualitative analysis to the primary provider for a psychiatric consult to determine the appropriateness of the medication and further medication management. Lakewood will review indications for all residents on antipsychotic medications by September 4, 2018. Once reviews are completed, the care center staff will audit any residents on antipsychotic medications to ensure there is an appropriate indication for the medication. Audits will be completed 5 days a week for 2 weeks, weekly for 2 weeks, and biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.	

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F 756	Continued From page 13	F 756		

The Psychotropic Medication Use Care Area Assessment (CAA) dated 1/9/18, indicated R8 received an antipsychotic medication, however, had not identified any psychotic behavior symptoms displayed by R8.

Review of the quarterly Mood and Behavior assessments dated 1/9/18, revealed R8 had no inappropriate mood or behavior symptoms.

Licensed practical nurse (LPN)-A was interviewed on 7/25/18, at 7:38 a.m. and stated R8 really did not have any inappropriate behavior symptoms except maybe making a sexual comment very occasionally like once a month or less, however, R8 was very easily redirected.

Trained medication aide (TMA)-A was also interviewed on 7/25/18, at 7:39 a.m. during which she stated R8 really did not have any inappropriate behavior symptoms except the occasional sexual comment.

R8 was observed on 7/24/18, from 2:13 p.m. to 3:58 p.m. and 7/25/18, from 7:12 a.m. to 2:15 p.m. and again on 7/26/18, from 9:30 a.m. to 11:30 a.m. during which R8 had not displayed any inappropriate or psychotic behaviors.

R8's Pharmacy Reviews dated 9/27/17, 10/25/17, 11/22/17, 12/27/17, 1/26/18, 2/26/18, 2/28/18, 3/4/18, 4/24/18, 5/3/18, 6/28/18, were reviewed and lacked evidence of the identification or lack thereof of psychotic behaviors displayed by R8 in order to justify the use of antipsychotic medication.

Review of the most recent Gradual Dose

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F 756	Continued From page 14 Reduction Review (GDR) form completed 6/14/18, and signed by R8's physician indicated R8 received Risperdal 2 mg every evening for a diagnosis of severe depressive psychosis. R8's behavior symptoms included yells out, yells at staff intermittently, indicated the behavior was easily redirected and R8 "Sleeps a lot." The pharmacist recommendation portion of the GDR form indicated R8 had a long standing history of psychotic behavior, and continued medication at the current dose was recommended. The pharmacist had not indicated what psychotic symptom's R8 displayed or how often they occurred. The physician indicated a gradual dose reduction not be attempted because any additional attempted dose reductions at this time would likely impair the resident's function or increase distressed behavior. The GDR form had not identified any psychotic behavior symptom's R8 displayed to justify the continued use of antipsychotic medication. The consultant pharmacist was interviewed via telephone on 7/26/18, at 4:46 p.m. during which he identified psychotic behavior as delusions, hallucinations, and/or expressions of unreasonable paranoia. The consultant pharmacist confirmed R8 did not have the aforementioned behavior symptoms of psychosis in order to justify the ongoing use of antipsychotic medication, and had not identified this medication irregularity during any of the pharmacy reviews from 9/24/17, through 6/28/18.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that	F 758		9/4/18

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F 758	Continued From page 15 affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.	F 758		

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F 758	Continued From page 16 §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to evaluate, monitor, and justify the continued use of psychoactive medications for 3 of 5 residents (R8, R24, R9) reviewed for unnecessary medications. Findings include: R8's face sheet dated 7/26/18, indicated R8's diagnoses included major depressive disorder with psychotic features, type II diabetes, and obesity. R8's annual Minimum Data Set (MDS) dated 1/3/18, and both quarterly MDS assessments dated 3/28/18, and 6/20/18, indicated R8 had moderate cognitive impairment, had no low mood symptoms, exhibited no inappropriate behavior symptoms, had no symptoms of psychosis (hallucinations, delusions, paranoia), and had no incidence of verbal or physical abuse or rejection of care. The MDS's indicated R8 required extensive assistance of one person for dressing, toilet use, and personal hygiene. The Psychotropic Medication Use Care Area Assessment (CAA) dated 1/9/18, indicated R8 received an antipsychotic medication, however, had not identified any psychotic behavior symptoms displayed by R8.	F 758	Lakewood will do an initial quantitative and qualitative analysis of behaviors noted in progress notes over the last 60 days for all residents on an antipsychotic medication by September 4th, 2018. Lakewood will review these findings with the provider. Lakewood updated the Psychoactive Medication and GDR policy to include specific language related to quantitative and qualitative analysis of behaviors in relation to antipsychotic medications. Lakewood will continue working with Stratis Health to develop a plan to reduce use of antipsychotic medications and develop continued qualitative and quantitative analyses with audits to monitor effectiveness of medications and interventions. The care center staff will audit nursing documentation for behaviors of any resident on antipsychotic medication. Audits will be completed 5 days a week for 2 weeks, weekly for 2 weeks, and biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.	

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Review of the quarterly Mood and Behavior assessments dated 1/9/18, revealed R8 had no inappropriate mood or behavior symptoms.

Review of R8's current physician orders (undated) indicated R8 had been receiving Risperdal 2 mg (antipsychotic medication) every evening since 2/18/14, for target behaviors of yelling, hitting staff during cares, refusing cares, swearing at staff, attempting to leave the building, wandering, and making constant requests of being hungry after eating. R8 had no target behaviors which indicated R8 had psychosis (hallucinations, delusions, paranoia) in order to justify the use of an antipsychotic medication.

Review of R8's progress notes from 3/1/18-7/25/18, indicated R8 yelled out either requesting food or voiced complaints of hunger nine times, had made inappropriate sexual comments twice, and either attempted to leave the building or threatened to leave the building on five occasions. R8's progress notes reviewed had not identified any psychotic behavior (hallucination's, delusion's, or unreasonable paranoia).

On 7/25/18, at 7:38 a.m. licensed practical nurse (LPN)-A stated R8 really did not have any inappropriate behavior symptoms except maybe making a sexual comment very occasionally like once a month or less, however, R8 was very easily redirected.

Trained medication aide (TMA)-A was also interviewed on 7/25/18, at 7:39 a.m. during which she stated R8 really did not have any inappropriate behavior symptoms except the occasional sexual comment.

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R8 was observed on 7/24/18, from 2:13 p.m. to 3:58 p.m. and 7/25/18, from 7:12 a.m. to 2:15 p.m. and again on 7/26/18, from 9:30 a.m. to 11:30 a.m. during which R8 had not displayed any inappropriate or psychotic behaviors.

R8's Pharmacy Reviews dated 9/27/17, 10/25/17, 11/22/17, 12/27/17, 1/26/18, 2/26/18, 2/28/18, 3/4/18, 4/24/18, 5/3/18, 6/28/18, were reviewed and lacked evidence of the identification of or the lack thereof of psychotic behaviors displayed by R8 in order to justify the use of antipsychotic medication.

Review of the most recent Gradual Dose Reduction Review (GDR) form completed 6/14/18, and signed by R8's physician indicated R8 received Risperdal 2 mg every evening for a diagnosis of severe depressive psychosis. R8's behavior symptoms included yells out, yells at staff intermittently, indicated the behavior was easily redirected and R8 "Sleeps a lot." The pharmacist recommendation portion of the GDR form indicated R8 had a long standing history of psychotic behavior, and continued medication at the current dose was recommended. The pharmacist had not indicated what psychotic symptom's R8 displayed or how often they occurred. The physician indicated a gradual dose reduction not be attempted because any additional attempted dose reductions at this time would likely impair the resident's function or increase distressed behavior. The GDR form had not identified any psychotic behavior symptom's R8 displayed to justify the continued use of antipsychotic medication.

The director of nursing (DON) was interviewed on

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7/26/18, at 2:57 p.m. and confirmed R8 did not have an appropriate indication for the use of antipsychotic medication because R8 had not displayed psychotic behavior symptoms.

The consultant pharmacist was interviewed via telephone on 7/26/18, at 4:46 p.m. during which he identified psychotic behavior as delusions, hallucinations, and/or expressions of unreasonable paranoia. The consultant pharmacist confirmed R8 did not have the aforementioned behavior symptoms of psychosis to justify the ongoing use of antipsychotic medication, and had not identified this medication irregularity during any of the pharmacy reviews from 9/24/17, through 6/28/18.

R9's annual MDS dated 7/4/18, indicated R9 had severe cognitive impairment and diagnoses including dementia with behaviors, aortic stenosis and atrial fibrillation. The MDS indicated R9 displayed mood indicators such as feeling tired and having little energy. R9 displayed physical behaviors towards other 2-6 days a week and displayed verbal behaviors 1-3 times per week. The MDS indicated R9 required extensive assistance with all activities of daily living and she received anti-psychotic medications daily.

R9's Psychotropic Medication CAA dated 7/7/18, indicated R9 displayed behaviors when the staff attempted to assist with cares or ambulation.

R9's care plan dated 4/4/18, indicated R9 displayed behaviors such as being resistive to cares and combative with staff during cares. The care plan indicated R9 required the use of Seroquel (anti-psychotic medication) to decrease the behaviors.

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R9's Physicians orders indicated the following orders:

- 3/25/18, R9 started on Seroquel (antipsychotic) 25 milligrams (mg) at bedtime.
- 4/19/18, R9's Seroquel was increased to 50 mg at bedtime.
- 6/13/18, R9's Seroquel was increased to 75 mg at bedtime. If no significant improvement in two weeks. may increased to 100 mg at bedtime.

R9's Physician Progress notes indicated the following information:

- On 4/19/18, the physician indicated R9's dementia was declining and had significant behavioral issues. Due to behaviors, the Seroquel had been increased.

- On 6/13/18, the physician indicated R9 had behavioral changes and was agitated or upset for most of the day. The physician's plan was to increase the Seroquel to 75 mg and if significant behaviors had not improved in two weeks, the medication was to be increased to 100 mg.

The facility completed a gradual dose reduction review on 7/2/18, and indicated R9 had intermittent confusion due to disease process. The facility was working on finding the correct dose for R9 and gradual dose increases were being completed to determine the appropriate effective dose.

On 7/26/18, at 8:00 a.m. R9 was observed resting in be, watching television. R9 was not observed to display any type of behaviors.

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- At 9:26 a.m. NA-C stated R9 would become combative any time the staff assisted he with personal cares. NA-C stated R9 would elbow the staff members in the chest/breast area. She would yell and strike others. NA-A stated to decrease R9's behaviors, R9 was to be approached calmly with one staff member as she would become more combative with additional staff in the room.

- At 11:00 a.m. NA-A and NA-B stated R9 would become very combative during cares. R9 would hit, kick and slap at the staff members. NA-A stated the staff had to be very slow when assisting with cares and try to ensure R9 understood what was about to happen before cares were completed. NA-A stated R9 may act as if she understood the cares, however, R9 would hit out when the staff members attempted to complete the cares.

Review of R9's Progress Notes from 4/1/18 - 7/26/18, indicated R9 had intermittent episodes of behaviors which included hitting, slapping and being resistive to cares.

R9's clinical record did not include a monitoring system in which R9's behaviors were monitored after starting the Seroquel nor did the record indicate how the facility was going to determine if R9's behaviors became better or worse following the medication changes.

R9's record contained a Gradual Dose Reduction Review dated 4/19/18. The nursing staff had indicated R9 displayed intermitted confusion related to disease process, irritability and was combative with the staff members. The consultant pharmacist had indicated R9 was on

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25 mg of Seroquel at bedtime and recommended no dose adjustments at that time. The Physician responded to the report and directed the increase of the medication to 50 mg at bedtime.

R9's record contained a second Gradual Dose Reduction Review dated 6/29/18. R9 was receiving 75 mg of Seroquel at bedtime. The nursing staff indicated R9 displayed behaviors. The pharmacist recommended the dose to remain the same. The physician signed the form but did not make a comment regarding the current dose.

On 7/26/18, at 9:40 a.m. the DON confirmed R9 displayed physical and verbal aggression during cares. The DON explained the facility documented behaviors by exception, therefore, the only documentation regarding behaviors would be completed after the behaviors had occurred and all behavior documentation would be located in the progress notes. The DON stated the facility did not have a system to monitor the quantitative or qualitative effectiveness of the medications in relationship to R9's behaviors. The interdisciplinary team (IDT) members would discuss any concerns during IDT meetings, however, there was no formal monitoring of the behaviors. In addition, the DON confirmed R9's record lacked documentation related to how she responded to the initiation of the Seroquel or how she responded when the medication was increased.

R24's annual MDS dated 9/6/17, identified R24 had diagnoses including dementia, anxiety disorder and depression. The MDS also indicated R24 did not experience hallucination or delusions and had no behaviors. R24 was

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receiving antipsychotic, antianxiety and antidepressant medications.

R24's Care Planning Report provided 7/26/18, indicated R24's target behaviors included auditory hallucinations, paranoia, intermittent confusion, irritability, delusions, self deprecating statements, verbal and physical behaviors affecting others, throwing of objects at staff, yelling at staff and falsifying medical conditions for attention. The plan indicated R24 received antipsychotic, antianxiety and antidepressant medications. Approaches included allow resident to express concerns, offer words of encouragement and comfort if resident is upset, allow resident to be by herself in her room and reduce stimulation. Staff to document behaviors every shift.

R24's current physician's orders included Remeron (antidepressant) 15 milligrams (mg) daily at bedtime for major depressive disorder, Xanax (antianxiety) 0.25 mg every morning for unspecified dementia with behavioral disturbance, Xanax 0.5 mg at bedtime for anxiety disorder and Seroquel 37.5 mg at 3pm daily for major depressive disorder.

R24's Mood Behavior Assessments indicated the following:
- 12/4/17 - no mood symptoms present - no hallucinations/delusions
- 9/4/17 - no mood symptoms present - no hallucinations/delusions
- 2/26/18 - feeling down, depressed or hopeless 2-6 days; poor appetite or overeating 2-6 days - no hallucinations/delusions
- 5/21/18 - feeling down, depressed or hopeless 7-11 days; trouble sleeping 7-11 days; feeling tired or having little energy 7-11 days; poor

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appetite or overeating 7-11 days; - no hallucinations/delusions

R24's Psychosocial Questionnaire indicated the following:
-12/4/17 - easily loses temper or becomes upset; complains or whines; arouses during the night
- 9/4/17 - easily loses temper or becomes upset; complains or whines; arouses during the night; delusional ideation e.g., accuses others of things that are untrue
- 2/26/18 - easily loses temper or becomes upset; complains or whines; arouses during the night
- 5/21/18 - easily loses temper or becomes upset; complains or whines; arouses during the night

R24's Summary Responses to Behavioral Symptoms from 7/1/17 to 7/26/18, indicated R24's behavior symptoms as: displayed:
- verbally abusive behavior symptoms did not occur
- physically abusive behaviors did not occur
- socially inappropriate or disruptive behaviors occurred 4-7 days

R24's GDR reviews dated 10/01/17, 10/3/17, 4/5/18, 6/10/18 and 6/12/18, all included the same nursing comment which indicated R24 had a history of hallucinations, history of paranoia, intermittent confusion and irritability. History of delusional self-deprecating statements, verbal and physical behaviors. All pharmacist recommendations indicated decreasing medication would decrease resident's quality of life, recommend to stay at same dose.

Review of R24's progress notes indicated R24 was experiencing identified target behaviors although lacked a quantitative review of those

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behaviors to determine the efficacy of the prescribed medications.

On 7/25/18, at 9:11 a.m. R24 was observed sitting quietly in her room, watching television.

On 7/25/18, at 9:16 a.m. NA-D stated that when R24 demonstrated behaviors, the staff would ask her what they could do for her or why she was unhappy. Staff would offer the bathroom, coffee or if R24 wanted to call a family member. NA-D stated R24 was usually pretty easy to re-direct and the staff tried alternatives first and if unable to resolve the behavior, the staff would let the nurse know.

On 7/26/18, at 9:39 a.m. the DON stated target behaviors were identified on the care plan and behavior monitoring was documented in the progress notes. The DON stated that GDR's did not show if behaviors increased or decreased and no quantitative review was done which would have included: how many times the behaviors occurred during the month, a general review of how often the behaviors had occurred.
-At 9:57 a.m. registered nurse (RN)-A stated resident behaviors were reviewed weekly, at the high risk meetings. RN-A stated that quantitative reviews of resident behaviors were not completed.

Review of the facilities policy Psychoactive Medication and GDR (gradual dose reduction) dated 10/10, and last reviewed 12/17, indicated that if an antipsychotic medication was ordered for use, there needed to be an acceptable diagnosis or condition documented in the residents clinical record. The policy identified a

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F 758	Continued From page 26 list of 10 different diagnoses that were appropriate indications for the use of antipsychotic medications. The policy had not identified what behavioral symptoms must be present to justify the use of antipsychotic medication.	F 758		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all residents were consistently offered and provided a substantial evening snack for 5 of 5 residents (R20, R3, R2, R5, R12) who voiced a concern and had the potential to affect all 26 residents residing in the facility.	F 809	Lakewood developed a nightly check list for staff to fill out when they offer snack at HS. Lakewood staff will offer each resident a snack as appropriate, unless sleeping, out of facility, or on tube feedings and will document their response on the check list. Lakewood will make	9/4/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	600 MAIN AVENUE SOUTH BAUDETTE, MN 56623

(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 809	Continued From page 27 Findings include: A resident group interview was completed on 7/24/18, at 1:15 p.m. and R20, R3, R2, R5 and R12 stated evening snacks were not consistently offered every evening. The residents stated that a snack cart was brought out to the nurses station every evening between 7:00 and 8:00 p.m. however, some nursing assistants did not bring the cart around and ask all the residents if they would enjoy an evening snack. On 7/23/18, at 6:53 p.m. R20 stated a snack was not offered every evening before bedtime and that most resident's independently went out to the nursing station and obtained whatever snack they desired from the snack cart. R20 also stated he lived at the end of a long hallway and could not walk all the way to the nurses station to get a snack without having pain. Evening observations were conducted on 7/23/18, from 4:00 p.m. to 7:45 p.m. during which it was noted that the dietary department delivered a snack cart with several types of snacks and beverages to the nurses station at approximately 7:00 p.m.. Two residents independently took snack items from the cart however, the staff were not observed delivering the snack cart to all the resident rooms in order to provide a snack or allow the non-independent residents the opportunity to have an evening snack before going to bed. On 7/25/18, at 8:35 a.m. nursing assistant (NA)-B stated the kitchen staff provided a snack cart every evening so the residents' who wanted an evening snack could have one but was not sure if	F 809	snack cart available after evening meal until breakfast the next day for those that choose to have a snack later in the night. Lakewood will educate staff on HS snack checklist. The education will be provided to the care center nursing staff by DON by September 4, 2018. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. The care center staff will audit the check list for offering of snacks and do observational audits to ensure compliance. Audits will be completed 5 days a week for 2 weeks, weekly for 2 weeks, and biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 809	Continued From page 28 all the residents were consistently offered an evening snack every night. On 7/26/18, at 4:29 p.m. the director of nursing (DON) stated she expected all residents to be offered an evening snack. The DON also stated she was unsure if the facility had a policy related to offering residents evening snacks, but would provide a policy if the facility had one. A facility policy related to offering residents evening snacks was not provided.	F 809		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**07/24/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**600 MAIN AVENUE SOUTH BAUDETTE, MN 56623**

(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 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 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. 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 Care Center 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF	K 000	EPOC	

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

Electronically Signed | 08/17/2018

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
	245580	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**07/24/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**600 MAIN AVENUE SOUTH** **BAUDETTE, MN 56623**

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K 000	Continued From page 1 CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 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. Lakewood Care Center is a 1-story building without a basement and with a penthouse. The building was constructed in 2000, was determined to be of Type V (111) construction and is attached to the hospital building which is separated with a 2- hour fire barrier. The facility is divided into 3 smoke zones by 1- hour fire barriers. The building is fully sprinkler protected with a dry pipe sprinkler system and also has a manual fire	K 000		

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	245580	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**07/24/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**600 MAIN AVENUE SOUTH BAUDETTE, MN 56623**

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K 000	Continued From page 2 alarm system with corridor smoke detection and smoke detection in spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 35 beds and had a census of 25 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in	K 351	Lakewood has scheduled Nova Fire Protection INC to replace the gauge and it	9/20/18

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	245580	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**07/24/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**600 MAIN AVENUE SOUTH BAUDETTE, MN 56623**

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K 351	Continued From page 3 accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (10) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 35 of 35 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:30 a.m. to 2:30 p.m. on 07/24/2018, observations revealed that in the mechanical room located across from administrator's office has a sprinkler riser system that has a gauge that has not been tested or calibrated every 5 years. This deficient condition was confirmed by a Maintenance Supervisor.	K 351	will be corrected on or before September 20th, 2018. Nova inspects Lakewood□s Fire Protection systems and sprinkler systems. NOVA Fire Protection 304 41st S Fargo ND 58103, 701-362-0702. Chris Bowman, Facility manager will monitor to prevent reoccurrence.	
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,	K 914		7/30/18

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	245580	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**07/24/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**600 MAIN AVENUE SOUTH** **BAUDETTE, MN 56623**

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K 914	Continued From page 4 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. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 35 of 35 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:30 a.m. to 2:00 p.m. on 07/24/2018, during a records review and an interview with the Maintenance Supervisor, it was determined that the facility had not completed finished the annual electrical outlet inspection and testing for the electrical outlets located in the patient/resident care areas located throughout the facility. This deficient condition was confirmed by a Maintenance Supervisor.	K 914	Lakewood completed annual electrical outlet inspection and testing for electrical outlets by July 30th, 2018. Lakewood developed a preventative maintenance schedule for future inspections to maintain compliance with regulations. Compliance will be monitored by Chris Bowman, Facilities Manager.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 10, 2018

Mr. Jeffry Stampohar, Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN 56623

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5580029

Dear Mr. Stampohar:

The above facility was surveyed on July 23, 2018 through July 26, 2018 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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 contact:

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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
	00332	A. BUILDING: _____ B. WING _____	07/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	600 MAIN AVENUE SOUTH BAUDETTE, MN 56623

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On July 23-26, 2018, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 000	Continued From page 2 "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.	2 000		
21035	MN Rule 4658.0620 Subp. 2 Frequency of Meals; Snacks Subp. 2. Snacks. The nursing home must offer evening snacks daily. "Offer" means having snacks available and making the resident aware of that availability. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure all residents were consistently offered and provided a substantial evening snack for 5 of 5 residents (R20, R3, R2, R5, R12) who voiced a concern and had the potential to affect all 26 residents residing in the facility. Findings include: A resident group interview was completed on 7/24/18, at 1:15 p.m. and R20, R3, R2, R5 and R12 stated evening snacks were not consistently offered every evening. The residents stated that a snack cart was brought out to the nurses station every evening between 7:00 and 8:00 p.m. however, some nursing assistants did not bring the cart around and ask all the residents if they would enjoy an evening snack. On 7/23/18, at 6:53 p.m. R20 stated a snack was	21035	corrected	9/4/18

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21035	Continued From page 3	21035		

not offered every evening before bedtime and that most resident's independently went out to the nursing station and obtained whatever snack they desired from the snack cart. R20 also stated he lived at the end of a long hallway and could not walk all the way to the nurses station to get a snack without having pain.

Evening observations were conducted on 7/23/18, from 4:00 p.m. to 7:45 p.m. during which it was noted that the dietary department delivered a snack cart with several types of snacks and beverages to the nurses station at approximately 7:00 p.m.. Two residents independently took snack items from the cart however, the staff were not observed delivering the snack cart to all the resident rooms in order to provide a snack or allow the non-independent residents the opportunity to have an evening snack before going to bed.

On 7/25/18, at 8:35 a.m. nursing assistant (NA)-B stated the kitchen staff provided a snack cart every evening so the residents' who wanted an evening snack could have one but was not sure if all the residents were consistently offered an evening snack every night.

On 7/26/18, at 4:29 p.m. the director of nursing (DON) stated she expected all residents to be offered an evening snack. The DON also stated she was unsure if the facility had a policy related to offering residents evening snacks, but would provide a policy if the facility had one. A facility policy related to offering residents evening snacks was not provided.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) and/or designee

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(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
21035	Continued From page 4 could review or revise policies, and provide education for staff regarding provision of HS snacks. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21035		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review	21530		9/4/18

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21530	Continued From page 5 if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility pharmacist failed to ensure antipsychotic medications had appropriate indications for their use for 1 of 5 residents (R8) reviewed for unnecessary medications. Findings include: R8's face sheet dated 7/26/18, indicated R8's diagnoses included major depressive disorder with psychotic features, type II diabetes, and obesity. R8's annual Minimum Data Set (MDS) dated 1/3/18, and both quarterly MDS assessments dated 3/28/18, and 6/20/18, indicated R8 had moderate cognitive impairment, had no low mood symptoms, exhibited no inappropriate behavior symptoms, had no symptoms of psychosis (hallucinations, delusions, paranoia), and had no incidence of verbal or physical abuse or rejection of care. The MDS's indicated R8 required extensive assistance of one person for dressing, toilet use, and personal hygiene.	21530	corrected	

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21530	Continued From page 6	21530		

Review of R8's current physician orders (undated) indicated R8 had been receiving Risperdal 2 mg (antipsychotic medication) every evening since 2/18/14, for target behaviors of yelling, hitting staff during cares, refusing cares, swearing at staff, attempting to leave the building, wandering, and making constant requests of being hungry after eating. R8 had no target behaviors which indicated R8 had psychosis (hallucinations, delusions, paranoia) in order to justify the use of an antipsychotic medication.

Review of R8's progress notes from 3/1/18-7/25/18, indicated R8 yelled out either requesting food or voiced complaints of hunger nine times, had made inappropriate sexual comments twice, and either attempted to leave the building or threatened to leave the building on five occasions. R8's progress notes reviewed had not identified any psychotic behavior (hallucination's, delusion's, or unreasonable paranoia).

The Psychotropic Medication Use Care Area Assessment (CAA) dated 1/9/18, indicated R8 received an antipsychotic medication, however, had not identified any psychotic behavior symptoms displayed by R8.

Review of the quarterly Mood and Behavior assessments dated 1/9/18, revealed R8 had no inappropriate mood or behavior symptoms.

Licensed practical nurse (LPN)-A was interviewed on 7/25/18, at 7:38 a.m. and stated R8 really did not have any inappropriate behavior symptoms except maybe making a sexual comment very occasionally like once a month or less, however, R8 was very easily redirected.

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Trained medication aide (TMA)-A was also interviewed on 7/25/18, at 7:39 a.m. during which she stated R8 really did not have any inappropriate behavior symptoms except the occasional sexual comment.

R8 was observed on 7/24/18, from 2:13 p.m. to 3:58 p.m. and 7/25/18, from 7:12 a.m. to 2:15 p.m. and again on 7/26/18, from 9:30 a.m. to 11:30 a.m. during which R8 had not displayed any inappropriate or psychotic behaviors.

R8's Pharmacy Reviews dated 9/27/17, 10/25/17, 11/22/17, 12/27/17, 1/26/18, 2/26/18, 2/28/18, 3/4/18, 4/24/18, 5/3/18, 6/28/18, were reviewed and lacked evidence of the identification or lack thereof of psychotic behaviors displayed by R8 in order to justify the use of antipsychotic medication.

Review of the most recent Gradual Dose Reduction Review (GDR) form completed 6/14/18, and signed by R8's physician indicated R8 received Risperdal 2 mg every evening for a diagnosis of severe depressive psychosis. R8's behavior symptoms included yells out, yells at staff intermittently, indicated the behavior was easily redirected and R8 "Sleeps a lot." The pharmacist recommendation portion of the GDR form indicated R8 had a long standing history of psychotic behavior, and continued medication at the current dose was recommended. The pharmacist had not indicated what psychotic symptom's R8 displayed or how often they occurred. The physician indicated a gradual dose reduction not be attempted because any additional attempted dose reductions at this time would likely impair the resident's function or increase distressed behavior. The GDR form had not identified any psychotic behavior symptom's

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21530	Continued From page 8 R8 displayed to justify the continued use of antipsychotic medication. The consultant pharmacist was interviewed via telephone on 7/26/18, at 4:46 p.m. during which he identified psychotic behavior as delusions, hallucinations, and/or expressions of unreasonable paranoia. The consultant pharmacist confirmed R8 did not have the aforementioned behavior symptoms of psychosis in order to justify the ongoing use of antipsychotic medication, and had not identified this medication irregularity during any of the pharmacy reviews from 9/24/17, through 6/28/18. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures identifying residents have adequate indications for the use of antipsychotic medications. Nursing staff could be educated as necessary to the importance of identifying and monitoring psychotic behaviors. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug	21535		9/4/18

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21535	Continued From page 9 therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to evaluate, monitor, and justify the continued use of psychoactive medications for 3 of 5 residents (R8, R24, R9) reviewed for unnecessary medications. Findings include: R8's face sheet dated 7/26/18, indicated R8's diagnoses included major depressive disorder with psychotic features, type II diabetes, and obesity. R8's annual Minimum Data Set (MDS) dated 1/3/18, and both quarterly MDS assessments dated 3/28/18, and 6/20/18, indicated R8 had moderate cognitive impairment, had no low mood	21535	corrected	

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symptoms, exhibited no inappropriate behavior symptoms, had no symptoms of psychosis (hallucinations, delusions, paranoia), and had no incidence of verbal or physical abuse or rejection of care. The MDS's indicated R8 required extensive assistance of one person for dressing, toilet use, and personal hygiene.

The Psychotropic Medication Use Care Area Assessment (CAA) dated 1/9/18, indicated R8 received an antipsychotic medication, however, had not identified any psychotic behavior symptoms displayed by R8.

Review of the quarterly Mood and Behavior assessments dated 1/9/18, revealed R8 had no inappropriate mood or behavior symptoms.

Review of R8's current physician orders (undated) indicated R8 had been receiving Risperdal 2 mg (antipsychotic medication) every evening since 2/18/14, for target behaviors of yelling, hitting staff during cares, refusing cares, swearing at staff, attempting to leave the building, wandering, and making constant requests of being hungry after eating. R8 had no target behaviors which indicated R8 had psychosis (hallucinations, delusions, paranoia) in order to justify the use of an antipsychotic medication.

Review of R8's progress notes from 3/1/18-7/25/18, indicated R8 yelled out either requesting food or voiced complaints of hunger nine times, had made inappropriate sexual comments twice, and either attempted to leave the building or threatened to leave the building on five occasions. R8's progress notes reviewed had not identified any psychotic behavior (hallucination's, delusion's, or unreasonable paranoia).

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21535	Continued From page 11 On 7/25/18, at 7:38 a.m. licensed practical nurse (LPN)-A stated R8 really did not have any inappropriate behavior symptoms except maybe making a sexual comment very occasionally like once a month or less, however, R8 was very easily redirected. Trained medication aide (TMA)-A was also interviewed on 7/25/18, at 7:39 a.m. during which she stated R8 really did not have any inappropriate behavior symptoms except the occasional sexual comment. R8 was observed on 7/24/18, from 2:13 p.m. to 3:58 p.m. and 7/25/18, from 7:12 a.m. to 2:15 p.m. and again on 7/26/18, from 9:30 a.m. to 11:30 a.m. during which R8 had not displayed any inappropriate or psychotic behaviors. R8's Pharmacy Reviews dated 9/27/17, 10/25/17, 11/22/17, 12/27/17, 1/26/18, 2/26/18, 2/28/18, 3/4/18, 4/24/18, 5/3/18, 6/28/18, were reviewed and lacked evidence of the identification of or the lack thereof of psychotic behaviors displayed by R8 in order to justify the use of antipsychotic medication. Review of the most recent Gradual Dose Reduction Review (GDR) form completed 6/14/18, and signed by R8's physician indicated R8 received Risperdal 2 mg every evening for a diagnosis of severe depressive psychosis. R8's behavior symptoms included yells out, yells at staff intermittently, indicated the behavior was easily redirected and R8 "Sleeps a lot." The pharmacist recommendation portion of the GDR form indicated R8 had a long standing history of psychotic behavior, and continued medication at the current dose was recommended. The	21535		

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pharmacist had not indicated what psychotic symptom's R8 displayed or how often they occurred. The physician indicated a gradual dose reduction not be attempted because any additional attempted dose reductions at this time would likely impair the resident's function or increase distressed behavior. The GDR form had not identified any psychotic behavior symptom's R8 displayed to justify the continued use of antipsychotic medication.

The director of nursing (DON) was interviewed on 7/26/18, at 2:57 p.m. and confirmed R8 did not have an appropriate indication for the use of antipsychotic medication because R8 had not displayed psychotic behavior symptoms.

The consultant pharmacist was interviewed via telephone on 7/26/18, at 4:46 p.m. during which he identified psychotic behavior as delusions, hallucinations, and/or expressions of unreasonable paranoia. The consultant pharmacist confirmed R8 did not have the aforementioned behavior symptoms of psychosis to justify the ongoing use of antipsychotic medication, and had not identified this medication irregularity during any of the pharmacy reviews from 9/24/17, through 6/28/18.

R9's annual MDS dated 7/4/18, indicated R9 had severe cognitive impairment and diagnoses including dementia with behaviors, aortic stenosis and atrial fibrillation. The MDS indicated R9 displayed mood indicators such as feeling tired and having little energy. R9 displayed physical behaviors towards other 2-6 days a week and displayed verbal behaviors 1-3 times per week. The MDS indicated R9 required extensive assistance with all activities of daily living and she

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received anti-psychotic medications daily.

R9's Psychotropic Medication CAA dated 7/7/18, indicated R9 displayed behaviors when the staff attempted to assist with cares or ambulation.

R9's care plan dated 4/4/18, indicated R9 displayed behaviors such as being resistive to cares and combative with staff during cares. The care plan indicated R9 required the use of Seroquel (anti-psychotic medication) to decrease the behaviors.

R9's Physicians orders indicated the following orders:

- 3/25/18, R9 started on Seroquel (antipsychotic) 25 milligrams (mg) at bedtime.
- 4/19/18, R9's Seroquel was increased to 50 mg at bedtime.
- 6/13/18, R9's Seroquel was increased to 75 mg at bedtime. If no significant improvement in two weeks. may increased to 100 mg at bedtime.

R9's Physician Progress notes indicated the following information:

- On 4/19/18, the physician indicated R9's dementia was declining and had significant behavioral issues. Due to behaviors, the Seroquel had been increased.

- On 6/13/18, the physician indicated R9 had behavioral changes and was agitated or upset for most of the day. The physician's plan was to increase the Seroquel to 75 mg and if significant behaviors had not improved in two weeks, the medication was to be increased to 100 mg.

The facility completed a gradual dose reduction

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review on 7/2/18, and indicated R9 had intermittent confusion due to disease process. The facility was working on finding the correct dose for R9 and gradual dose increases were being completed to determine the appropriate effective dose.

On 7/26/18, at 8:00 a.m. R9 was observed resting in be, watching television. R9 was not observed to display any type of behaviors.

- At 9:26 a.m. NA-C stated R9 would become combative any time the staff assisted he with personal cares. NA-C stated R9 would elbow the staff members in the chest/breast area. She would yell and strike others. NA-A stated to decrease R9's behaviors, R9 was to be approached calmly with one staff member as she would become more combative with additional staff in the room.

- At 11:00 a.m. NA-A and NA-B stated R9 would become very combative during cares. R9 would hit, kick and slap at the staff members. NA-A stated the staff had to be very slow when assisting with cares and try to ensure R9 understood what was about to happen before cares were completed. NA-A stated R9 may act as if she understood the cares, however, R9 would hit out when the staff members attempted to complete the cares.

Review of R9's Progress Notes from 4/1/18 - 7/26/18, indicated R9 had intermittent episodes of behaviors which included hitting, slapping and being resistive to cares.

R9's clinical record did not include a monitoring system in which R9's behaviors were monitored after starting the Seroquel nor did the record

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indicate how the facility was going to determine if R9's behaviors became better or worse following the medication changes.

R9's record contained a Gradual Dose Reduction Review dated 4/19/18. The nursing staff had indicated R9 displayed intermitted confusion related to disease process, irritability and was combative with the staff members. The consultant pharmacist had indicated R9 was on 25 mg of Seroquel at bedtime and recommended no dose adjustments at that time. The Physician responded to the report and directed the increase of the medication to 50 mg at bedtime.

R9's record contained a second Gradual Dose Reduction Review dated 6/29/18. R9 was receiving 75 mg of Seroquel at bedtime. The nursing staff indicated R9 displayed behaviors. The pharmacist recommended the dose to remain the same. The physician signed the form but did not make a comment regarding the current dose.

On 7/26/18, at 9:40 a.m. the DON confirmed R9 displayed physical and verbal aggression during cares. The DON explained the facility documented behaviors by exception, therefore, the only documentation regarding behaviors would be completed after the behaviors had occurred and all behavior documentation would be located in the progress notes. The DON stated the facility did not have a system to monitor the quantitative or qualitative effectiveness of the medications in relationship to R9's behaviors. The interdisciplinary team (IDT) members would discuss any concerns during IDT meetings, however, there was no formal monitoring of the behaviors. In addition, the DON confirmed R9's record lacked documentation

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related to how she responded to the initiation of the Seroquel or how she responded when the medication was increased.

R24's annual MDS dated 9/6/17, identified R24 had diagnoses including dementia, anxiety disorder and depression. The MDS also indicated R24 did not experience hallucination or delusions and had no behaviors. R24 was receiving antipsychotic, antianxiety and antidepressant medications.

R24's Care Planning Report provided 7/26/18, indicated R24's target behaviors included auditory hallucinations, paranoia, intermittent confusion, irritability, delusions, self deprecating statements, verbal and physical behaviors affecting others, throwing of objects at staff, yelling at staff and falsifying medical conditions for attention. The plan indicated R24 received antipsychotic, antianxiety and antidepressant medications. Approaches included allow resident to express concerns, offer words of encouragement and comfort if resident is upset, allow resident to be by herself in her room and reduce stimulation. Staff to document behaviors every shift.

R24's current physician's orders included Remeron (antidepressant) 15 milligrams (mg) daily at bedtime for major depressive disorder, Xanax (antianxiety) 0.25 mg every morning for unspecified dementia with behavioral disturbance, Xanax 0.5 mg at bedtime for anxiety disorder and Seroquel 37.5 mg at 3pm daily for major depressive disorder.

R24's Mood Behavior Assessments indicated the following:
- 12/4/17 - no mood symptoms present - no hallucinations/delusions

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	00332	A. BUILDING: _____ B. WING _____	07/26/2018

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LAKEWOOD CARE CENTER	600 MAIN AVENUE SOUTH BAUDETTE, MN 56623

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- 9/4/17 - no mood symptoms present - no hallucinations/delusions
- 2/26/18 - feeling down, depressed or hopeless 2-6 days; poor appetite or overeating 2-6 days - no hallucinations/delusions
- 5/21/18 - feeling down, depressed or hopeless 7-11 days; trouble sleeping 7-11 days; feeling tired or having little energy 7-11 days; poor appetite or overeating 7-11 days; - no hallucinations/delusions

R24's Psychosocial Questionnaire indicated the following:
-12/4/17 - easily loses temper or becomes upset; complains or whines; arouses during the night
- 9/4/17 - easily loses temper or becomes upset; complains or whines; arouses during the night; delusional ideation e.g., accuses others of things that are untrue
- 2/26/18 - easily loses temper or becomes upset; complains or whines; arouses during the night
- 5/21/18 - easily loses temper or becomes upset; complains or whines; arouses during the night

R24's Summary Responses to Behavioral Symptoms from 7/1/17 to 7/26/18, indicated R24's behavior symptoms as: displayed:
- verbally abusive behavior symptoms did not occur
- physically abusive behaviors did not occur
- socially inappropriate or disruptive behaviors occurred 4-7 days

R24's GDR reviews dated 10/01/17, 10/3/17, 4/5/18, 6/10/18 and 6/12/18, all included the same nursing comment which indicated R24 had a history of hallucinations, history of paranoia, intermittent confusion and irritability. History of delusional self-deprecating statements, verbal and physical behaviors. All pharmacist

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recommendations indicated decreasing medication would decrease resident's quality of life, recommend to stay at same dose.

Review of R24's progress notes indicated R24 was experiencing identified target behaviors although lacked a quantitative review of those behaviors to determine the efficacy of the prescribed medications.

On 7/25/18, at 9:11 a.m. R24 was observed sitting quietly in her room, watching television.

On 7/25/18, at 9:16 a.m. NA-D stated that when R24 demonstrated behaviors, the staff would ask her what they could do for her or why she was unhappy. Staff would offer the bathroom, coffee or if R24 wanted to call a family member. NA-D stated R24 was usually pretty easy to re-direct and the staff tried alternatives first and if unable to resolve the behavior, the staff would let the nurse know.

On 7/26/18, at 9:39 a.m. the DON stated target behaviors were identified on the care plan and behavior monitoring was documented in the progress notes. The DON stated that GDR's did not show if behaviors increased or decreased and no quantitative review was done which would have included: how many times the behaviors occurred during the month, a general review of how often the behaviors had occurred.
-At 9:57 a.m. registered nurse (RN)-A stated resident behaviors were reviewed weekly, at the high risk meetings. RN-A stated that quantitative reviews of resident behaviors were not completed.

Review of the facilities policy Psychoactive

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21535	Continued From page 19 Medication and GDR (gradual dose reduction) dated 10/10, and last reviewed 12/17, indicated that if an antipsychotic medication was ordered for use, there needed to be an acceptable diagnosis or condition documented in the residents clinical record. The policy identified a list of 10 different diagnoses that were appropriate indications for the use of antipsychotic medications. The policy had not identified what behavioral symptoms must be present to justify the use of antipsychotic medication. SUGGESTED METHOD OF CORRECTION: The facility could develop and implement a process for monitoring and evaluation of target behaviors and interventions to ensure psychotropic medication is effective and justifiable, and implement an auditing system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21855	MN St. Statute 144.651 Subd. 15 Patients & Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.	21855		9/4/18

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21855	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure confidential information was not readily available for all residents, staff and visitors to view for 1 of 1 resident (R7) observed to have personal care information posted in their room. Findings include: R7's quarterly Minimum Data Set (MDS) dated 7/11/18, indicated R7 had diagnoses including transient ischemic attack (TIA) and unspecified kidney failure. The MDS also indicated R7 had intact cognition, was totally dependent on staff for activities of daily living (ADL's), and had an indwelling urinary catheter. On 7/23/18, at 2:54 p.m. an 8 x 11 piece of paper was observed posted on R7's wall, above the head of bed, which read "Catheter: Ensure there is slack on catheter tubing at all times. Tubing must be secured with a leg strap at all times. Be careful with cares. Do not pull on catheter." On 7/26/18, at 1:02 p.m. the director of nursing (DON) stated she was not aware of confidential care information having been posted on R7's wall and would immediately remove it. The DON verified personal resident care information should not be posted in areas that was readily visible to others. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could establish training initiatives for employees to	21855	corrected	

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21855	Continued From page 21 ensure Resident Rights which included privacy was a clearly defined facility practice. he DON or designee could develop an auditing system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21855		