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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6S5Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00451

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245374**
2.STATE VENDOR OR MEDICAID NO.
(L2) **177550201**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKESIDE MEDICAL CENTER**
(L4) **129 EAST 6TH AVENUE**
(L5) **PINE CITY, MN** (L6) **55063**

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 **09/04/2014** (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 **46** (L18)

13.Total Certified Beds **46** (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
	46			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Kathie Killoran, HFE NE II — 09/18/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 10/16/2014 (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
02/01/1987
(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
Posted 10/27/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/10/2014
(L33)

DETERMINATION APPROVAL

CCN: 245374

On September 4, 2014 a Post Certification Revisit was completed at this facility and verified correction of deficiencies issued pursuant to an extended survey completed on July 15, 2014 where conditions in the facility at the time of the extended survey constituted substandard quality of care and immediate jeopardy to residents health or safety. Effective August 25, 2014, the deficiencies issued pursuant to the extended survey were corrected. As a result of the revisit, this Department discontinued State monitoring as of August 25, 2014.

In addition, we recommended the following action to the CMS Region V Office related to the remedies outlined in our letter of September 18, 2014:

- Civil Money Penalty for deficiency cited at F323, effective July 7, 2014, remain in effect.

As a result of the extended survey and identifying SQC, the facility is subject to a two year loss of NATCEP, effective July 15, 2014

Refer to the CMS 2567b for the results of this visit.

Effective August 25, 2014, the facility is certified for 46 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245374
September 18, 2014

Mr. Max Blaufuss, Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, Minnesota 55063

Dear Mr. Blaufuss:

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 August 25, 2014 the above facility is certified for:

46 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697 5374r14

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 18, 2014

Mr. Max Blaufuss, Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, Minnesota 55063

RE: Project Number S5374023

Dear Mr. Blaufuss:

On July 31, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective August 5, 2014. (42 CFR 488.422)

On July 31, 2014, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on July 15, 2014. At the time of the extended survey conditions in the facility constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to resident health or safety. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On September 4, 2014, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on July 15, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 25, 2014. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on July 15, 2014, as of August 25, 2014.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 25, 2014.

However, as we notified you in our letter of July 31, 2014, 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 July 15, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedy in our letter of July 31, 2014:

- Civil money penalty for the deficiency cited at F323, remain in effect. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5374r14

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245374	A. Building B. Wing	9/4/2014

Name of Facility	Street Address, City, State, Zip Code
LAKESIDE MEDICAL CENTER	129 EAST 6TH AVENUE PINE CITY, MN 55063

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **08/25/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **08/25/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **08/25/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **08/25/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/25/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **08/25/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/25/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **08/25/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/25/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **08/25/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/25/2014**	ID Prefix **F0514** Reg. # **483.75(l)(1)** LSC	Correction Completed **08/25/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PLH/mm	09/17/2014	29625	09/24/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
7/15/2014			

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

September 18, 2014

Mr. Max Blaufuss, Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, Minnesota 55063

Re: Reinspection Results - Project Number S5374023

Dear Mr. Blaufuss:

On September 4, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 15, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5374r2_s14

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00451	A. Building B. Wing	9/4/2014

Name of Facility	Street Address, City, State, Zip Code
LAKESIDE MEDICAL CENTER	129 EAST 6TH AVENUE PINE CITY, MN 55063

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **08/25/2014**	ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **08/25/2014**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **08/25/2014**
ID Prefix **20625** Reg. # **MN Rule 4658.0450 Subp.** LSC	Correction Completed **08/25/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **08/25/2014**	ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **08/25/2014**
ID Prefix **21015** Reg. # **MN Rule 4658.0610 Subp.** LSC	Correction Completed **08/25/2014**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **08/25/2014**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Su** LSC	Correction Completed **08/25/2014**
ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **08/25/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/15/2014	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6S5Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00451

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245374**
2.STATE VENDOR OR MEDICAID NO.
(L2) **177550201**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKESIDE MEDICAL CENTER**
(L4) **129 EAST 6TH AVENUE**
(L5) **PINE CITY, MN** (L6) **55063**

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 **07/15/2014** (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 **46** (L18)

13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 08/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/08/2014 (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
02/01/1987
(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

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 245374

On July 15, 2014 an extended survey was completed at this facility. At the time of the extended survey conditions in the facility constituted Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to resident health or safety. Before the survey team exited the survey the facility had a removal plan and removed the IJ on July 12, 2014. The facility is not given an opportunity to corrected before remedies are imposed. As a result this Department imposed the Category 1 rememdy of State monitoring, effective August 5, 2014. In addition, we recommended the following remedies to the CMS Region V Office for imposition:

Civil Money Penalty for deficiency cited at F323, effective July 7, 2014

As a result of the extended survey and idenfying SQC, the facility is subject to a two year loss of NATCEP, effective July 15, 2014.

Refer to the CMS 2567 for both health and life safety code, along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Submitted
July 31, 2014

Mr. Max Blaufuss, Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, Minnesota 55063

RE: Project Number S5374023

Dear Mr. Blaufuss:

On July 15, 2014, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;
Appeal Rights - the facility rights to appeal imposed remedies;

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on July 12, 2014, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Patricia Halverson, Supervisor
Duluth Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Patricia.halverson@state.mn.us

Phone: (218) 302-6151
Fax: (218) 340-6623

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective August 5, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323, effective July 7, 2014. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Lakeside Medical Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 15, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director

330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 remedy be imposed:

• 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by October 15, 2014 (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 15, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

eel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	07/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MEDICAL CENTER	129 EAST 6TH AVENUE PINE CITY, MN 55063

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On July 7, 8, 9, 10, 11, 12, 14 and 15, 2014, surveyors of this department's staff visited the above provider and the following federal deficiencies are issued. A monitoring visit was made on July 12, 2014, and an extended survey was completed on July 14 and 15, 2014. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to comprehensively assess for causal factors and risks related to falls which resulted in harm and the high potential for further harm or death for R49. Facility staff were notified of the IJ on July 10, 2014, at 5:15 p.m. The immediate jeopardy which began on 5/23/14, was removed on 7/12/14, at 3:47 p.m.; however, non-compliance remained at the lower scope and severity level of G, which indicated actual harm that was not immediate jeopardy. 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Census: 29	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		8/25/14

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

Electronically Signed | 08/08/2014

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure the physician was contacted when necessary for 1 of 1 resident (R25) reviewed with specific parameters for	F 157	Nurse who did not notify MD of R25□s weight gain was verbally re-educated on 7/16/14. R25 was seen by Geriatric Nurse Practitioner on 07/8/14 , 07/10/14	

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F 157	Continued From page 2 notification. Findings include: R25's physician was not notified for weight gain according to physician ordered parameters. R25 had multiple diagnoses according to the current physician orders for 7/14, including congestive heart failure (CHF), and atrial fibrillation. On 3/6/13, R25 received a physician's order to monitor signs and symptoms of excess fluids and report a weight gain of greater than three pounds in 24-hours or greater than five pounds in one week, increased edema (swelling), shortness of breath, difficulty breathing and hypertension. On 7/7/14, at 6:20 p.m. R25 reported feeling, "I can't get my breath and I'll have trouble breathing especially if I lay down." R25 further stated she had been having more trouble breathing the past week or two, but she was to see the nurse practitioner "tomorrow - I feel like I have to check into it." When asked on 7/9/14, at 12:30 p.m. what the nurse practitioner thought about how she was feeling, R25 replied she [the nurse practitioner] "never came around. My name wasn't on the list." Review of R25's weight record revealed between 7/1/14 and 7/6/14, she had gained seven pounds. From 7/10/14 and 7/11/14, R25 gained three pounds. In May from 5/17/14 to 5/23/14, R25 gained five pounds. Record review revealed the physician/nurse practitioner had not been notified of the weight change for any of the identified gains. Further, the record identified no other symptoms of excess fluids had been monitored. On 7/10/14, at 7:10 a.m. the director of nursing	F 157	and 07/11/14 and weights were addressed. R25 was seen by Physician on 07/03/14. Nurse made a note on lung sounds and edema on 07/11/14. GNP notified on 07/12/14 of weight gain and nurse made note. GNP notified on 07/14/14 and nurse made note. R25 seen by GNP on 07/15/14. R25□s treatment sheet includes monitoring for signs and symptoms of excess fluids each shift.** (asterisks) have been added to the daily vital sheet where R25□s weight is recorded to alert CNA to verbally notify Nurse if resident has a weight gain. Care plan and CNA worksheets were updated on 07/30/14 to include daily weights with instructions to notify nurse of weight gain. CNA□s have been verbally educated one on one regarding importance of notifying nurse of weight gain by R 25, and again in person at inservice on 07/31/14. Notification policy and procedure has been reviewed and revised to include that even if a Resident□s Health Care Provider is notified in person of a status change, a note must be made in the Resident□s progress notes regarding the notification. All licensed staff will be verbally re-educated on the Notification policy at Nurse□s meeting on 08/13/14 and 08/14/14. All other residents with a diagnosis of CHF were reviewed by NP on 07/22/14 to confirm how often they should be weighed and what weight gain should be reported. The ADON, DON, or her designee will complete weekly audits until compliance is reached and quarterly thereafter or as needed. The results of such audits will be reviewed by the DON	

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F 157	Continued From page 3 (DON) verified the weight gains. DON stated the staff member working the medication cart was to enter the data into the computer and if there were changes identified the staff member was to notify the physician. She further indicated if the staff member was a TMA (Trained Medication Aide) they were to notify the nurse. DON also verified the physician/nurse practitioner should have been notified for the identified weight gains.	F 157	and thereafter take any necessary actions. The results of such audits will be reported to the facility Quality Assurance Committee and Committee will make further recommendations regarding ongoing audits. DON, in conjunction with the ADON, to monitor and assure compliance. Completion date: 08/25/14.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278		8/25/14

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F 278	Continued From page 4 material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to accurately assess the oral status of 1 of 3 residents (R30) reviewed for pain. Findings include: R30 had missing and broken teeth which impacted her ability to chew, yet she was assessed to have no oral care issues. According to the dental Chart Progress Note dated 1/20/14, R30 had tooth extractions, exposed roots and had more extractions required. On 7/7/14 at 6:00 p.m. R30 was observed to have multiple missing teeth as well as teeth broken off at the gumline. At the time, R30 stated she had a problem with her teeth for awhile and it impacted her ability to chew. R30 stated she requested dietary to grind her meat as she was unable to chew meats. The care plan dated as reviewed on 6/14, identified a mechanical soft (ground meat) diet. The MDS 3.0 Oral/Dental Assessment dated as completed on 10/13, identified obvious broken teeth "root tips" and "missing teeth." However the significant change MDS assessment for 10/13, identified R30 had no oral issues, no broken teeth and no Care Area Assessment (CAA) needed to be completed. The quarterly MDS assessment on 4/14, also identified no oral issues. On 7/10/14, at 8:15 a.m. registered nurse (RN)-A	F 278	R30 has a current treatment plan in progress with Apple Tree dental to have her extractions completed. A dental concern form was sent to Apple Tree on 07/16 to ensure R 30 would be seen on the next visit to facility. Apple Tree re-screened R 30 on 07/17/14. R30□s dental status was discussed with her and her niece at care conference on 07/18/14, and R30 was encouraged to travel to the twin cities to have more of the dental work completed sooner. Resident agreed and is scheduled to go to Apple Tree Aug 5th for more work. Care plan updated on 07/25/14 to address pain and assistance with oral cares. 10/13 MDS Corrected on 08/01/14. MDS Nurse counseled/re-educated regarding utilizing dental screen information for completion of oral section of MDS. All Residents will now have a comprehensive oral assessment done by Apple tree dental quarterly in addition to annually or with significant change. DON to randomly audit oral section "L" of MDS. DON or her designee will randomly audit Resident assessments to insure accuracy and revise prn. R30 was screened by PTA for am transfer status on 07/28/14. Trial of using total mechanical lift (hoyer) out of bed in am was initiated as this is when R30 states her pain is present. On 7/29 trial was discontinued because R30 stated she did	

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F 278	Continued From page 5 indicated she was unsure why she coded R30's MDS as no oral issues. At 9:00 am RN-A confirmed she coded the MDS incorrectly and verified R30 did have issues with her teeth/oral cavity and oral cares which needed to be assessed. R30's Pain Assessment was incomplete. R30 complained of significant pain with getting out of bed and morning cares which was not accurately assessed. According to physician progress notes, R30 had multiple diagnoses including degenerative joint disease (DJD) and neuropathy. R30's CAA dated 10/10/13, identified pain as an issue for R30, but failed to identify her significant pain issues in the morning with cares and use of the mechanical stand assist machine. The assessment failed to identify efficacy of any pharmacological and non-pharmacological interventions. Further, the assessment failed to identify any interventions intended to address the early morning pain. The Pain Assessment dated 7/3/14, also failed to identify the significant morning pain for R30. The assessment identified R30 verbalized almost constant pain yet, "Facial expressions and body language did not match description of pain complaints with resident." On 7/7/14, at 5:50 p.m. R30 stated, "I'm very pained in the morning. When I wake up it's especially bad." On 7/9/14, at 7:05 a.m. nursing assistant (NA)-A and NA-B both verified R30 had significant pain in the morning when she got up. On 7/10/14, at 8:15 a.m. RN-A stated R30 did not want to be awakened for pain pills. She further stated PT (physical therapy) had worked with R30 and the NP (nurse practitioner) had addressed	F 278	not like the hoyer and wanted to go back to using the EZ stand. PT Evaluation ordered to further explore Resident□s transfer needs, completed on 07/29/14. Resident agreed to have range of motion performed prior to getting up in the am for pain management. New pain assessment was completed on 07/21/14, with an addendum on 08/05/14. R30 has been seen 5 times between March and July 2014 and pain was addressed at those visits and was seen again by GNP on 07/29/14 regarding pain management. Per GNP Resident□s short term memory is very limited and R30 does make repetitive statements of pain, but generally denies pain in the moment. Resident has varying reports of pain without associated symptoms. Difficult to ascertain if pain vs dementia and fixation on historical pain- noted that narcotic increase 4 times didn□t help pain control reports On 08/05/14 pain management was again reviewed by GNP along with DON and Asst Administrator. Discussion was held regarding non pharmacological pain interventions, appropriate pain scale to use with resident, and availability of a pain medication that could be used at bedtime that would potentially offer some relief in the morning. Norco was discontinued and Oxycontin (long acting) was added at hour of sleep. Percocet was added prn, and muscle rub ointment was added to am (in addition to range of motion) Will continue to evaluate interventions for effectiveness. Other Residents with similar needs were reviewed and pain assessments were	

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F 278	Continued From page 6 the pain for R30. RN-A verified there were no other pain assessments completed for R30. The facility's Pain Assessment policy dated as reviewed on 6/20/14, verified all residents should have pain assessed and receive treatment which included "specific pain management programs."	F 278	revised as needed. The ADON, DON, or her designee will complete weekly audits until compliance is reached and quarterly thereafter or as needed. The results of such audits will be reviewed by the DON and thereafter take any necessary actions. The results of such audits will be reported to facility Quality Assurance Committee and Committee will make further recommendations regarding ongoing audits. DON, in conjunction with the ADON, to monitor and assure compliance. Completion date: 08/25/14.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		8/25/14

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F 279	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and revise the comprehensive care plan for 1 of 4 residents (R49) reviewed for falls and 1 of 1 resident (R15) reviewed for behaviors. Findings include: R49's Admission Record dated 6/20/12, identified diagnoses to include dementia, depression, anxiety, peripheral neuropathy, congestive heart failure, chronic obstructive airway disease and chronic kidney disease (moderate). The annual Minimum Data Set (MDS) dated 5/20/14, indicated R49 was cognitively intact, had little interest or pleasure in doing things, had no behavior problems, and required extensive assistance of two staff with bed mobility, transfers and toileting. The MDS further identified R49 did not ambulate, had occasional incontinence of bladder, had scheduled pain medications with no signs or symptoms of pain, and had a history of falls (two or more since the last assessment), one with a minor injury, none with a major injury. R49's care plan dated as revised on 5/21/14, indicated a potential for falls related to weakness, confusion, psychoactive drug use, likes to sit at edge of chairs. The goal was for R49 to be free of falls. The care plan identified the following interventions: note resident had a history of kneeling at bedside to pray, unplug electric recliner when unsupervised in room to prevent sliding out of chair, and encourage to sleep in bed at night rather than recliner chair. R49 had eight falls between 3/28/14, and 7/8/14, (including a fall	F 279	R49□s care plan reviewed and updated on 07/10/14, 07/11, 07/22 and 07/25 to include safety interventions for fall prevention. Staff educated verbally and in writing of interventions on 07/10 and 07/11 and in writing on 07/22 and 07/25 with additions made to CNA worksheets. Falls assessments completed 07/10, 07/16 and 07/22/14. Comprehensive careplans for each resident were reviewed and revised as needed to ensure safety interventions for falls prevention are present and to ensure behavior interventions are appropriate. Use of the careplan policy and procedure dated 6/21/93 was reviewed and revised on 08/07/14 to include that the careplan will be reviewed weekly by the Licensed Nurse as part of the weekly charting. Nurse□s updated to policy change on 08/08/14 verbally and in writing and will be educated again on 08/13/14 and 08/14/14. Nurses have been educated verbally and in writing on updating/revising care plans to include falls intervention, behaviors and staff intervention on 8/7-8/8 and will be educated again on 08/13/14 and 08/14/14 Nurse□s meetings. Incident report was updated to include prompt to update care plan after an incident if appropriate. The DON, ADON, or her designee will complete weekly audits until compliance is reached and quarterly thereafter or as needed. The results of such audits will be reviewed by the DON and thereafter take any necessary actions. The results of	

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F 279	Continued From page 8 with a hip fracture on 5/23/14), and the facility did not update the care plan. R15 was admitted to the facility on 2/14/14, and expired on 3/14/14. R15's Admission Record dated 2/14/14, identified diagnoses to include rheumatoid arthritis, hypertension, leukocytosis, and myalgia. R15's admission MDS dated 2/20/14, indicated R15 was cognitively intact, and had no mood or behavior problems. It further identified R15 required minimal assistance of one staff for bed mobility, moderate assistance of one staff for ambulation in room/corridor, and extensive assistance of one staff for toileting, dressing and personal hygiene. R15's significant change MDS dated 3/6/14, identified changes in R15's condition which included mood indicators of: little interest in doing things, trouble falling asleep or sleeping too much, feeling tired or having little energy and poor appetite. The significant change MDS identified behavior problems which included behavior symptoms: directed at others (e.g. hitting, kicking, pursing, scratching, grabbing). The significant change MDS also identified R15 required increased staff assistance of extensive assistance of two staff for bed mobility, transfers, and toileting. The Care Area Assessment (CAA) dated 3/13/14, indicated R15 had behaviors of biting staff with cares, screaming for help instead of using call light, combative with blood draw. Interventions identified in the CAA included cares were explained to R15 prior to procedures, staff would provide comfort measures and pain control, and R15 enrolled in Hospice on 3/12/14. R15's Progress Notes indicated the following	F 279	such audits will be reported to facility Quality Assurance Committee and Committee will make further recommendations regarding ongoing audits. DON, in conjunction with the ADON, to monitor and assure compliance. Completion date: 08/25/14	

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	245374	A. BUILDING _____ B. WING _____	07/15/2014

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F 279	Continued From page 9 regarding behaviors: *On 2/27/14, R15 refused occupational therapy (OT), refused to get out of bed, and had aggressive behaviors with nursing staff. *On 2/27/14, R15 was on the toilet and was noted to be throwing herself backwards causing bruising to her back. R15 had many attention seeking behaviors, and had increases made to her narcotic pain management by the nurse practitioner (NP) on Tuesday. A call was placed to NP to update her on R15's current condition/behaviors. *On 3/2/14, R15 bit a nursing assistant during transfers and stated she did it because she was crazy like her. *On 3/6/14, nursing staff found it difficult to determine level of orientation as R15 was confused and uncooperative with questions. Will get angry with staff for doing or not doing what she asks. *On 3/6/14, R15's behaviors included refusing cares, refusing to get up out of bed, becoming verbally and physically abusive (hitting out, pinching and biting). Staff was to reapproach and redirect. *On 3/12/14, R15's general condition had worsened, she demonstrated increased confusion, became combative with lab tech. NP recommended Hospice for failure to thrive. *On 3/12/14, R15 was thrashing about in bed, staff attempted to calm, but R15 grabbed and twisted staff fingers. R15 refused to open her	F 279		

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F 279	Continued From page 10 mouth to take Ativan (an antianxiety medication), and Vicodin (a narcotic pain reliever). The medications were given rectally and R15 was sleeping fifteen minutes later. R15's care planned lacked identification of behavior problems and staff interventions. On 7/10/14, at 12:46 p.m. the director of nursing (DON) stated she would expect fall interventions, behaviors and staff interventions to be on the care plan. The facility was unable to provide a policy and procedure on care plans.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure the care plan was followed for 1 of 1 resident (R25) care planned to monitor for excess fluid. Findings include: R25's care plan was not followed related to physician notification for weight gain. R25 had multiple orders including congestive heart failure (CHF), and atrial fibrillation. On 3/6/13, R25's care plan problem was initiated related to a	F 282	Nurse who did not notify MD of R25□s weight gain was verbally re-educated on 7/16/14. R25 was seen by Geriatric Nurse Practitioner on 07/8/14 , 07/10/14 and 07/11/14 and weights were addressed. R25 was seen by Physician on 07/03/14. Nurse made a note on lung sounds and edema on 07/11/14. GNP notified on 07/12/14 of weight gain and nurse made note. GNP notified on 07/14/14 and nurse made note. R25 seen by GNP on 07/15/14. R25□s treatment	8/25/14

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F 282	Continued From page 11 potential for fluid overload. Interventions included to monitor for excess fluid and report weight gains of greater than three pounds in 24-hours or five pounds in a week. Review of R25's weight record revealed between 7/1/14 and 7/6/14, she had gained seven pounds. From 7/10/14 and 7/11/14, R25 gained three pounds. In May from 5/17/14 to 5/23/14, R25 gained five pounds. Record review revealed the physician/nurse practitioner had not been notified of the change for any of the identified gains. Further, the record identified no other symptoms of excess fluids had been assessed. On 7/10/14, at 9:15 a.m. the trained medication aide (TMA)-A verified R25, "lets us know when she doesn't feel good. She tells us when she can't breathe very well and the nurses know." On 7/10/14, at 7:10 a.m. the director of nursing (DON) verified the care plan had not been followed. DON stated the "nurse on duty should be assessing her for those symptoms" and the physician/nurse practitioner should have been notified.	F 282	sheet was revised to match current physician orders and careplan. ** (asterisks) have been added to the daily vital sheet where R25□s weight is recorded to alert CNA to verbally notify Nurse if resident has a weight gain. Care plan and CNA worksheets were updated on 07/30/14 to include daily weights with instructions to notify nurse of weight gain. CNA□s have been verbally educated one on one regarding importance of notifying nurse of weight gain by R 25, and again in person at inservice on 07/31/14. Notification policy and procedure has been reviewed and revised to include that even if a Resident□s Health Care Provider is notified in person of a status change, a note must be made in the Resident□s progress notes regarding the notification. All licensed staff have been re-educated on the Notification policy and use of care plan policy and procedure either verbally or in writing and both policies will be reviewed again at Nurse□s meeting on 08/13/14 and 08/14/14. All other residents with a diagnosis of CHF were reviewed by NP on 07/22/14 to confirm how often they should be weighed and what weight gain should be reported. The ADON, DON, or her designee will complete weekly audits until compliance is reached and quarterly thereafter or as needed. The results of such audits will be reviewed by the DON and thereafter take any necessary actions. The results of such audits will be reported to facility Quality Assurance Committee and Committee will make further recommendations regarding ongoing	

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F 282	Continued From page 12	F 282	audits. DON, in conjunction with the ADON, to monitor and assure compliance. Completion date: 08/25/14.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide neurological assessment following a potential head injury for 1 of 4 residents (R51) reviewed for accidents and 2 of 2 residents (R25, R30) reviewed with pain/discomfort. Findings include: R51's Admission Record dated 1/14/14, indicated diagnoses including acute esophagitis, urinary tract infection, hypertension, failure to thrive, and dementia. The admission Minimum Data Set (MDS) assessment dated 1/16/14, indicated R51 had a moderate cognitive impairment, had no falls in the six months prior to admission, and required limited assist of one staff for bed mobility, transfers, and ambulation. The MDS further indicated R51 required extensive assist of one staff for locomotion of the wheelchair, dressing, toilet use, personal hygiene, and	F 309	R51:Neurological assessment policy and procedure and falls policy and procedure has been reviewed and revised to state that all residents who hit their head or have an unwitnessed fall will have neurological checks done. Incident report has been updated to state that all residents who hit their heads or have an unwitnessed fall will have neuros done, as a reminder to the Nurse filling out the incident report. Facility has implemented a fall follow up worksheet to insure that follow up charting after a fall is completed. Nurses were educated verbally or in writing on 08/07/14 and will be educated again at Nurse□s meetings on 08/13 and 08/14/14. R25: Nurse who did not notify MD of R25□s weight gain was verbally re-educated on 7/16/14. R25 was seen by Geriatric Nurse Practitioner on 07/8/14	8/25/14

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F 309	Continued From page 13 bathing, and was independent with eating. The nursing Progress Notes indicated R51 had a fall on 1/21/14, at 9:33 p.m. with significant injuries and was transferred to the hospital. R51 was treated at the hospital and returned to the facility on 1/23/14. R51's Interagency Transfer Form dated as printed on 1/23/14, indicated diagnoses included a fall with closed head injury, facial contusion (bruise), nasal fracture (broken nose), and facial laceration (cut), bradycardia (slow heart rate), complete atrioventricular (AV) block (irregular heart rhythm), and dizziness. The significant change MDS dated 1/29/14, indicated R51 had a decline in cognition to a severe cognitive impairment. Other changes in the MDS included increased need for assistance and required extensive assist of two staff with bed mobility and extensive assist of one staff for transfers and ambulation, and limited assistance with eating. The MDS further indicated R51 had more falls. The Fall Risk profile dated 1/12/14, indicated R51 was at increased risk for falls and interventions were initiated. The Fall Risk profile dated 1/23/14, addressed R51's risk factors, including the recent fall with injuries and addressed interventions in place. The care plan dated 1/13/14, indicated R51 was at risk for falls and identified safety devices used for fall prevention. The Hospice care plan dated 1/24/14, identified additional safety devices in place for R51. The nurse Progress Notes dated 1/26/14, at 10:38 p.m. indicated R51 had a fall next to the	F 309	, 07/10/14 and 07/11/14 and weights were addressed. R25 was seen by Physician on 07/03/14. Nurse made a note on lung sounds and edema on 07/11/14. GNP notified on 07/12/14 of weight gain and nurse made note. GNP notified on 07/14/14 and nurse made note. R25 seen by GNP on 07/15/14. R25□s treatment sheet includes monitoring for signs and symptoms of excess fluids each shift.** (asterisks) have been added to the daily vital sheet where R25□s weight is recorded to alert CNA to verbally notify Nurse if resident has a weight gain. Care plan and CNA worksheets were updated on 07/30/14 to include daily weights with instructions to notify nurse of weight gain. CNA□s have been verbally educated one on one regarding importance of notifying nurse of weight gain by R 25, and again in person at inservice on 07/31/14. Notification policy and procedure has been reviewed and revised to include that even if a Resident□s Health Care Provider is notified in person of a status change, a note must be made in the Resident□s progress notes regarding the notification. Licensed staff were educated verbally and in writing on 08/07/14 will be verbally re-educated on the Notification policy at Nurse□s meeting on 08/13/14 and 08/14/14. All other residents with a diagnosis of CHF were reviewed by NP on 07/22/14 to confirm how often they should be weighed and what weight gain should be reported. R30 was screened by PTA for am transfer status on 07/28/14. Trial of using total mechanical lift (hoyer) out of bed in am	

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F 309	Continued From page 14 bed. R51 stated she bumped her head on the mat and had no pain. The incident report for this incident indicated a neurological check and vital signs were done at that time. There was no evidence of complete neurological assessments to monitor for signs and symptoms of a head injury, and no follow-up documentation regarding the incident. On 7/15/14, at 1:19 p.m. the director of nursing (DON) verified neurological check assessments were not done when R51 hit her head on the fall mat on the floor. When it was explained R51 was at increased risk for further injury due to initial injury and neurological check assessments should have been completed, DON nodded in agreement and stated she understood. The Neurological Assessment Flowsheet policy and procedure dated as revised on 5/2000, directed the form should be used when the charge nurse had any reason to believe a resident had injured themselves, by striking his/her head in a fall, or having been struck in the head by some object. The Suspected Head Injury policy and procedure dated as revised on 11/07, directed the physician and resident's family was to be called if a head injury was suspected, a neurological check assessment was to be implemented, and follow-up charting was to be done in the nurse's notes for forty-eight hours. The policy and procedure lacked direction for specific situations when a neurological check assessment was to be completed. R25 expressed respiratory discomfort which was	F 309	was initiated as this is when R30 states her pain is present. On 7/29 trial was discontinued because R30 stated she did not like the hoyer and wanted to go back to using the EZ stand. PT Evaluation ordered to further explore Resident□s transfer needs, completed on 07/29/14. Resident agreed to have range of motion performed prior to getting up in the am for pain management. New pain assessment was completeed on 07/21/14, with an addendum on 08/05/14. R30 has been seen 5 times between March and July 2014 and pain was addressed at those visits and was seen again by GNP on 07/29/14 regarding pain management. Per GNP Resident□s short term memory is very limited and R30 does make repetitive statements of pain, but generally denies pain in the moment. Resident has varying reports of pain without associated symptoms. Difficult to ascertain if pain vs dementia and fixation on historical pain-noted that narcotic increase 4 times didn□t help pain control reportsOn 08/05/14 pain management was again reviewed by GNP along with DON and Asst Administrator. Discussion was held regarding non pharmacological pain interventions, appropriate pain scale to use with resident, and availability of a pain medication that could be used at bedtime that would potentially offer some relief in the morning. Norco was discontinued and Oxycontin was added at hour of sleep. Percocet was added prn, muscle rub ointment was added to am (in addition to range of motion).Will continue to evaluate interventions for effectiveness.	

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F 309	Continued From page 15 not monitored by facility staff. R25 had multiple diagnoses listed on the physician's orders including congestive heart failure (CHF), pacemaker, and atrial fibrillation. On 3/6/13, R25 received a physician's order to monitor signs and symptoms of excess fluids and report a weight gain of greater than three pounds in 24-hours or greater than five pounds in one week, increased edema (swelling), shortness of breath, difficulty breathing and hypertension. R25's plan of care, dated as last reviewed on 6/17/14, identified a potential for fluid volume overload and reflected the physician orders. Review of R25's weight record revealed between 7/1/14 and 7/6/14, she had gained seven pounds. From 7/10/14 and 7/11/14, R25 gained three pounds. In May, from 5/17/14 to 5/23/14, R25 gained five pounds. Further record review revealed the physician/nurse practitioner had not been notified of the change for any of the identified gains. However the section of the Treatment Administration Record (TAR) that directed and recorded daily weights, only directed staff to call the physician for a weight gain of greater than three pounds in a day. It lacked the direction for physician notification if greater than five pounds in a week. Further, the record identified no other symptoms of excess fluids had been assessed in conjunction with the weight gains. On 7/7/14, at 6:20 p.m. R25 reported feeling, "I can't get my breath and I'll have trouble breathing especially if I lay down." R25 further indicated she had been having more trouble breathing the past week or two, but stated she was to see the nurse practitioner "tomorrow - I feel like I have to check	F 309	Pain assessment policy and procedure has been reviewed and Nurses will be re-educated on policy verbally and in writing on 08/08/14 and will be reviewed again at Nurse□s meeting on 08/13 and 08/14/14. Residents with similar needs were reviewed and care plans revised as needed. The DON, ADON, or her designee will complete weekly audits until compliance is reached and quarterly thereafter or as needed. The results of such audits will be reviewed by the DON and thereafter take any necessary actions. The results of such audits will be reported to facility Quality Assurance Committee and Committee will make further recommendations regarding ongoing audits. DON, in conjunction with the ADON, to monitor and assure compliance. Completion date: 08/25/14.	

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F 309	Continued From page 16 into it." When asked on 7/9/14, at 12:30 p.m. what the nurse practitioner thought about how she was feeling, R25 replied she [the nurse practitioner] "never came around. My name wasn't on the list." R25 was aware of her extensive cardiac issues and was concerned about her difficulty breathing. "I don't know if there's water on my lungs or just trouble breathing." R25 stated she had gained weight and that was part of the concern. "The last couple weeks has been terrible, but now it's better probably because of the humidity being gone." On 7/10/14, at 9:15 a.m. trained medication aide (TMA)-A verified R25 was a reliable reporter and did inform staff when she was not feeling well. "Oh yeah, she lets us know when she doesn't feel good. She tells us when she can't breathe very well and the nurses know." On 7/10/14, at 7:10 a.m. the director of nursing (DON) stated the person working the medication cart was responsible for entering the daily weights and monitor for any weight gain. DON verified R25's weight gain should have been identified and R25 should have been assessed. DON further identified R25 should have been seen by the nurse practitioner on 7/8/14. DON confirmed if R25 had gained weight, there should have been an assessment for fluid retention and the assessment/plan should have been documented in the progress notes. "We should be watching her." R30 did not have an effective pain management program. R30 had multiple diagnoses according to the nurse practitioner Progress Note dated 7/10/14, including osteoarthrosis. R30's most recent Pain Assessment dated 7/3/14, identified	F 309		

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F 309	Continued From page 17 almost constant pain self reported to be "severe." However, the assessment also identified R30's facial expressions and body language did not match her complaints regarding the level of pain. The current plan of care dated as reviewed on 6/17/14, identified a goal of R30 verbalizing "adequate" pain control. Interventions included documenting the efficacy of as needed (PRN) medications, provide pain meds as ordered, question resident about pain and monitor for changes in pain. During initial interview with R30 on 7/7/14. at 5:50 p.m. she stated she had "terrible" pain in the morning with a.m. cares. She further stated she did not get anything for pain prior to getting out of bed in the morning, but could ask if she would like something for her pain. "In the morning when I wake up it's especially bad. The monster [the EZ-stand mechanical lift] causes horrible pain and it's very stressful. The pain is close to 10 [out of 0-10 pain scale]." R30 was observed to receive her morning cares on 7/9/14. At 6:55 a.m. nursing assistant (NA)-C inquired about her leg pain as she was positioning the mechanical lift. R30 was sitting up in bed with the assistance of NA-C as she stated, "My leg is so sore and painful." She was observed to be grimacing and rubbing her leg as she sat up. "The pain is terrible just terrible." As NA-C began to place her sock on the left foot, R30 gasped through clenched teeth, rubbed her face and attempted to withdraw her foot from the sock. R30 stated, "It's "always like this" when she gets up in the morning (regarding her pain level). As NA-C and NA-D began to stand R30 in the mechanical lift, R30 cried out loudly, "Oh my that hurts! Oh oh it hurts so!" NA-C and NA-D	F 309		

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F 309	Continued From page 18 immediately returned R30 to a sitting position and repositioned the lift. When R30 stated she was ready to attempt to stand again she effectively stood with the aid of the mechanical lift while grunting and repeating "Oh, Oh, Oh." When interviewed at 7:05 am, NA-C and NA-D verified the observed transfer was "how it goes" with R30 every morning. They both indicated R30 had significant pain in the morning with standing and cares. They further identified R30 felt better throughout the day as she "gets moving" and has her pain medications. They further stated, "Yep. Everyone knows this." On 7/9/14, at 7:15 am after both the NAs left the room, R30 stated she doesn't do any exercises with her lower extremities prior to getting out of bed. She further identified nothing was offered for pain management before getting out of bed. R30 stated she did not want to be awakened for pain medications and needed to use the bathroom when she woke up in the morning. She verified there were no other alternatives offered to assist with pain management in the morning did not involve waking her up to give medications. When asked to describe her pain, R30 stated in the morning it was a 10 on a scale of 0-10. She further indicated the pain was "deep" and ran from her foot up her legs to her hips. "It's horrible, just horrible." R30 reported the pain improved throughout the day as she received pain medications and moved around more. Review of the July physician's orders revealed R30 had an order for Norco (narcotic pain medication) 5/325 mg (milligrams) two tabs three times a day at a.m., noon and p.m. Review of the Medication Administration Record (MAR) indicated the times for administration of the Norco	F 309		

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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) COMPLETION DATE
F 309	Continued From page 19 were 8:00 a.m., noon, and 4:00 p.m. R30 could also have Norco 5/325 mg one tablet three times a day as needed for pain. Review of the MAR's for 5/14, revealed R30 received two doses of the PRN Norco on night shifts. In 6/14, R30 utilized seven PRN doses of Norco from 6/17-27/14, from 2:00 a.m. to 4:00 a.m. During 7/14, R30 utilized one PRN dose of Norco on 7/4/14, at 3:00 .am. When the physician orders and treatment records were reviewed, there was no evidence of non-pharmacological pain interventions. On 7/10/14, at 7:25 a.m. the DON stated R30 was seen by the nurse practitioner because her MDS identified pain as an issue. DON verified R30 had pain in the morning, but it was better later in the day "after she's had her pain meds." Interview with the MDS nurse at 8:15 a.m. revealed R30 has tried therapy as well as different pain medications without success. When asked what was meant in the pain assessment about her body language not matching up with her complaints of pain, the MDS nurse stated, "It's just that what she was telling me wasn't matching how she looked." The MDS nurse denied making those observations in the morning with cares. At 8:50 a.m., The physical therapy assistant (PTA)-F stated therapy had tried multiple interventions for R30's pain without much success. PTA-F further stated, "A lot of the pain she has too is the edema in her legs - we've done ace wraps we've done elevation - but she won't comply." On 7/10/14, at 9:00 a.m. R30's nurse practitioner (NP) stated R30 was actually describing a "chronic pain, generalized pain at a 5-6/10." NP indicated she saw R30 on 7/8/14, and R30 refused a change in pain meds and therapy.	F 309		

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	245374	A. BUILDING _____ B. WING _____	07/15/2014

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F 309	Continued From page 20 Review of NP progress note from this visit indicated NP educated R30 on the use of a pain scale and rated R30's pain at an 8, 9 or 10 indicated someone who needed to be hospitalized for pain management. After the education R30 stated her pain was a 5 or 6. The facility policy for Pain Assessment dated as reviewed on 6/20/14, verified residents should have "specific pain management programs" as appropriate. The policy included examples to consider for non-pharmacological interventions as well as principles for pharmacological intervention.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure residents received assistance with oral cares to maximize good oral health and maintain abilities for 1 of 3 residents (R30) reviewed for oral cares. Findings include: R30 did not receive the necessary assistance to ensure good oral care. A dental Chart Progress Note dated 1/20/14, indicated R30 required a dental extraction and would require more extractions. R30 was noted to have caries and exposed roots. There was no comprehensive	F 311	R30 has a current treatment plan in progress with Apple Tree dental to have her extractions completed. A dental concern form was sent to Apple Tree on 07/16 to ensure R 30 would be seen on the next visit to facility. Apple Tree re-screened R 30 on 07/17/14. (screen prior to that was 10/24/13) R30□s dental status was discussed with her and her niece at care conference on 07/18/14, and R30 was encouraged to travel to the twin cities to have more of the dental work completed sooner. Resident agreed and is scheduled to go to Apple Tree Aug 5th	8/25/14

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F 311	Continued From page 21 assessment completed on R30's oral status. However, the care plan dated as reviewed on 6/17/14, identified R30 required staff assistance for brushing/rinsing teeth and dentures with morning/evening cares. On 7/7/14, at 6:00 p.m. R30 was observed to have multiple missing teeth as well as teeth broken off at the gumline and stated she had a problem with her teeth for awhile and it impacted her ability to chew. R30 stated she requested dietary to grind her meat as she was unable to chew meats. R30's care plan dated as reviewed 6/14, identified a mechanical soft (ground meat) diet. On 7/9/14, at 7:05 a.m. both nursing assistants (NA)-C and NA-D stated R30 provided her own oral care and stated R30's oral care supplies were readily available on her night stand. On 7/9/14, at 7:40 a.m. R30 stated she took care of her own oral care and staff only brushed and soaked her dentures in the evening. R30 then dried them, applied denture adhesive and put them in place in the morning. R30 verified she did not brush her oral cavity or natural teeth. On 7/10/14, at 7:20 a.m. the director of nursing (DON) revealed she was unaware R30 was not receiving assistance or encouragement with oral cares. "I wasn't aware she didn't do any oral care."	F 311	for more dental work. Care plan updated on 07/25/14 to address assistance with oral cares (which prints the intervention on the CNA worksheet) . Staff re-educated verbally and in writing regarding need to assist R30 with her oral cares and verify that she is completing the task. Staff have been educated to notify the nurse if a Resident refuses oral care if they are not performing the task so the plan of care can be revised. The ADON, DON, or her designee will complete weekly audits until compliance is reached and quarterly thereafter or as needed. The results of such audits will be reviewed by the DON and thereafter take any necessary actions. The results of such audits will be reported to facility Quality Assurance Committee and Committee will make further recommendations regarding ongoing audits. DON, in conjunction with the ADON, to monitor and assure compliance. Completion date: 08/25/14.	
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		8/25/14

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F 323	Continued From page 22 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility demonstrated a systematic failure to comprehensively assess and effectively implement interventions in order to minimize the risk of falls for for 2 of 3 residents (R49, R39) reviewed with a history of falls, which resulted in an immediate jeopardy for R49 who sustained a fractured hip. In addition, the facility's failure to comprehensively assess and effectively implement interventions for falls resulted in actual harm for 1 of 3 residents (R49) reviewed with a history of falls, who sustained a hip fracture. The immediate jeopardy began on 5/23/14, when R49 sustained a right hip fracture as a result of a fall. The immediate jeopardy was identified on 7/10/14, and the administrator and director of nursing (DON) were notified of the immediate jeopardy on 7/10/14, at 5:15 p.m. The immediate jeopardy was removed on 7/12/14, at 3:47 p.m.; however, non-compliance remained at the lower scope and severity level of G, which indicated actual harm that was not immediate jeopardy. In addition, there was no assessment to determine safety of the bed against the wall following a bruised forehead during repositioning for 1 of 4 residents (R48) reviewed for accidents. Findings include: R49's re-admission record dated 5/27/14,	F 323	R49□s care plan reviewed and updated on 07/10/14, 07/11, 07/22 and 07/25 to include safety interventions for fall prevention. Staff educated verbally and in writing of interventions on 07/10 and 07/11 and in writing on 07/22 and 07/25 with additions made to CNA worksheets. Falls assessments completed 07/10, 07/16 and 07/22/14. R 49 seen by NP on 07/10/14- no new orders, awaiting dental appt on 07/11/14 for extraction. Consultant Pharmacist completed med review on 07/10/14. 15 minute visual checks implemented on 07/10/14 to insure safety. Due to delirium and falls out of recliner and wheelchair in the past, on 07/11/14 Recliner and wheelchair removed from room, Resident to use Broda chair when up out of bed (had been previously assessed for broda chair use on 05/31/14 and was using prn) On 07/11/14 seen again by NP before leaving for dental appt for 2 extractions. NP met with Falls Committee regarding R49□s falls and plan of care. On 07/15/14 and 07/17/14 NP saw Resident in follow up. R49 referred to Hospice by GNP on 07/22/14 after speaking to Resident and wife. Evaluated and admitted to Hospice on 07/24/14 with a primary diagnosis of dementia with behavioral disturbance.	

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F 323	Continued From page 23 identified diagnoses that included dementia, depression, anxiety, peripheral neuropathy, congestive heart failure, chronic obstructive airway disease and chronic kidney disease (moderate). The annual Minimum Data Set (MDS) dated 5/20/14, indicated R49 was cognitively intact, had little interest or pleasure in doing things, had no behavior problems, and required extensive assistance of two staff with bed mobility, transfers and toileting. The MDS further identified R49 did not ambulate, had occasional incontinence of bladder, had scheduled pain medications with no signs or symptoms of pain, and had a history of falls (2 or more since the last assessment), 1 with a minor injury, none with a major injury. R49's Fall Risk Profile checklist dated 5/16/14, indicated a high risk for falls. R49 was identified as having 3 falls from the recliner or wheelchair since the last assessment period. R49 had a history of self transfer attempts, sitting at the edge of a chair and sliding out of a chair. Interventions included a personal alarm to alert staff of self-transfers, keep call light within reach, staff to provide for comfort and safety and develop interventions as needed. The falls Care Area Assessment (CAA) dated 5/21/14, multiple falls without injury due toreaching for objects, itching legs or sitting on the edge fo the chair. Refuses staff interventions and will move self. New recliner has a built up base to allow proper placement in the seat with the standing lift. R49's care plan revised 5/21/14, indicated a potential for falls related to weakness, confusion,	F 323	Primary goal for resident is comfort. Resident has received hospice services in the past. IDT continues to discuss Resident condition to ensure current safety interventions remain appropriate. Safety audits for this resident have been implemented and are being completed. R39 had a new falls assessment completed on 07/10/14 and care plan updated to include safety interventions . Staff were made aware of changes verbally and in writing and via updated care worksheets. Consultant Pharmacist completed a medication review on 07/10 and made recommendations to GNP regarding administration time changes for a few medications. GNP was in agreement but R39□s spouse declined the changes. R30 seen by GNP on 07/22/14, no new orders or changes to plan of care. Seen by MD 08/07/14 and no new orders or changes to plan of care. R48: bed was moved away from wall on 07/15/14 after incident reviewed by IDT. Nurse who did not fill out an incident report after 6/16 incident has been verbally re-educated regarding situations that require an incident report. The Resident incident report and investigation policy and procedure was reviewed and all staff were re-educated verbally/in writing beginning on 08/08/14 and will also be reviewed at 08/13/14-08/14/14 nurse□s meetings. Nursing staff was re-educated on 07/31/14 regarding observing skin for any abnormalities and reporting them to the Nurse. Nursing and PT reviewed all residents who are dependant for bed mobility and currently have their beds	

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F 323	Continued From page 24 psychoactive drug use and sitting at the edge of chairs. The goal was for R49 to be free of falls. The care plan identified the following interventions: note that resident has a history of kneeling at bedside to pray, unplug electric recliner when unsupervised in room to prevent sliding out of chair, and encourage to sleep in bed at night rather than recliner chair. The care plan did not direct use of personal alarms or wedges under the footrest of the recliner. There was no evidence to indicate when safety alarms were first initiated. R49's Incident/Vulnerable Adult Report and Investigation documents indicated the following: *On 3/28/14, at 1:40 p.m. R49 was found sitting on floor in front of recliner with reacher, trying to grab the wheelchair. No injury was noted. The report indicated R49's antipsychotic medication Thorazine had been discontinued earlier in the week. New interventions to prevent recurrence were to inform the nurse practitioner. The 24 hour follow up indicated no further incidents, improved with medication changes (Thorazine restarted). *On 4/30/14, at 9:45 p.m. R49's call light was on and staff found him laying on his back flat on the floor. No injury was noted. R49 stated he was sleeping and when he woke up he was sliding out of the wheelchair. Although the resident stated he was sliding out of the wheelchair, the intervention to prevent recurrence was to put mat and a wedge under recliner and footrest to keep it from tipping forward. There was no assessment of the increased risk of injury from falling off of the elevated footrest. The conclusion dated 5/1/14, indicated the recliner was removed from the room, trial of a Broda Chair (a high-back tilting	F 323	against the wall for safety/appropriateness and changes were made as needed. Falls assessment and care plans were reviewed as revised as needed for Resident□s with similar needs. Resident Fall/ Found on floor policy and procedure was updated on 7/12/14 to include that the Licensed Nurse has the authority to add immediately add new interventions to prevent another fall. Staff has been educated to changes in the policy verbally and in writing starting 07/12/14. Fall Risk Profile assessment policy and procedure was updated on 07/10/14 to add that a new falls assessment will be done after a resident falls. Incident report has been updated to trigger staff to document what immediate interventions were implemented to keep a resident from falling again. Interdisciplinary team that meets 5 days per week and discusses all falls will make an entry in the progress note of residents discussed at IDT meeting and what interventions will be implemented, and care plans will be updated as these changes occur. IDT discussion will include root cause analysis and investigation, which will be documented in the medical record. PT and OT provided inservice training to all staff on 07/31/14 regarding falls prevention and examples of immediate interventions to implement to keep a resident safe. Written materials have been placed in the falls book on the unit for staff to reference and these items will be reviewed again at Nurse□s meeting on 08/13/ and 08/14/14. The ADON, DON, or her designee will	

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F 323	Continued From page 25 chair with wheels) and a therapy referral for bilateral lower extremity strengthening. There was no documentation to indicate the Broda chair was utilized and the care plan was not revised to reflect the changes. *On 5/4/14, at 11:05 p.m. the call light was on and R49 was found on the floor in his room. R49 stated he slid out of the wheelchair and crawled over to turn on the call light. No injury. New interventions to prevent recurrence were to remind R48 to use the call light and no independent transfers. There was no evidence of assessment to determine potential success of the suggested interventions that were known to be ineffective. *On 5/17/14, at 6:45 p.m. R49 was found on the floor beneath the recliner . There was no documentation regarding the recliner being returned to R49's room for use after 4/30/14. R49 stated he was trying to scratch his legs and slid out of the chair. R49 sustained a 3 centimeter (cm) abrasion on forehead, 3 cm abrasion on right knee, 1 cm x 1 cm abrasion on left wrist, 0.5 cm abrasion on left 5th finger and 0.5 cm abrasion on chin. New interventions to prevent recurrence included placing the bedside table within reach, reminding R49 to use call light and to use the reacher. The 24 hour follow up indicated no new injuries, neuros within normal limits. The care plan was not updated to reflect the suggested interventions. *On 5/23/14, at 6:40 a.m. R49 was found on the floor with the recliner footrest elevated. The fall report did not indicate whether the call light was on. R49 complained of right hip pain and was sent to the emergency room at 11:45 a.m. R49	F 323	complete weekly audits until compliance is reached and quarterly thereafter or as needed. The results of such audits will be reviewed by the DON and thereafter take any necessary actions. The results of such audits will be reported to facility Quality Assurance Committee and Committee will make further recommendations regarding ongoing audits. DON, in conjunction with the ADON, to monitor and assure compliance. Completion date: 08/25/14.	

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F 323	Continued From page 26 was admitted to the hospital for treatment of a right hip fracture. To prevent recurrence the base was removed from the recliner chair. The Fall Scene Investigation Report (FSI) was signed as complete on 5/26/14 with initial interventions of, "Placed in wheelchair. Need to consider something different with recliner." The care plan was not updated. There was no evidence of a comprehensive assessment to determine appropriate positioning and care needs following the fall with fracture when R49 returned to the facility on 5/27/14. The care plan was updated on 6/20/14, regarding use of the Broda chair for comfort as desired. There was no assessment of the Broda chair. *On 6/20/14, at 8:05 p.m. R49's personal alarm was sounding when he was found lying on the floor next to the recliner. The recliner was tipped forward. R49 stated he reached forward for something and tipped forward. No injury. The intervention to prevent recurrence was to place a wedge under the recliner footrest to prevent tipping forward. There was no assessment of the increased risk of injury from falling from the elevated footrest and the intervention was not added to the care plan. *Nursing progress notes dated 7/2/14, at 8:22 a.m., indicated R49 was found on the floor at 1:30 a.m., half way on the footrest of the recliner. R49 stated he was sliding down in the recliner to get comfortable. R49 was not injured and was assisted back into the recliner with the same alarms in place. The FSI dated 7/2/14 indicated R49 had required staff assistance for boosting up in the recliner due to sliding down for three hours prior to the fall at 1:30 a.m.. There was no	F 323		

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F 323	Continued From page 27 assessment to determine more appropriate seating for R49. *On 7/8/14, at 1:20 a.m. staff heard a noise and found R49 on the floor in his room. R49 had been in the wheelchair and had taken off the sweatshirt where the alarm was fastened. R49 stated he had pain and was moaning and shielding his left hip and leg. The ambulance was called; however, R49 refused to go to the hospital. Suggested interventions to prevent recurrence were to place R49 in the recliner with the alarm in place, call light within reach and remind him to call for help, again repeating the same ineffective interventions. *On 7/8/14, at 9:55 a.m. R49 was found on the floor in room, with the recliner tipped forward. R49 stated he was going to show the guy on TV how to tip a chair over. No injury. R49 was sent to the emergency room and returned to the facility with an abrasion on his heel from the fall. On 7/8/14, at 9:15 a.m. (prior to the last fall) R49 was observed in his room, seated in the recliner, attempting to pull his sweatshirt over his head. R49 was observed to continually move and appeared restless and jittery. R49 was not able to carry on a logical conversation. Nursing assistant (NA)-E removed R49's sweatshirt and clipped the personal alarm to his T-shirt. NA-E stated R49 had been like this all morning so they were keeping the room door open to keep a closer eye on him. On 7/9/14, R49 was observed to be asleep in a Broda chair at 8:42 a.m., at 11:03 a.m., at 12:47 p.m., at 1:50 p.m. and at 2:22 p.m..	F 323		

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F 323	Continued From page 28 The director of nurses (DON), interviewed on 7/9/14, at 2:24 p.m., stated R49 had fallen on 7/8/14, at 1:20 a.m., having removed his sweater with the alarm attached. R49 had been confused and not acting like himself. The DON further stated no injury was noted, but the ambulance was called, and R49 refused to go with them. R49 had also fallen on 7/8/14, at 9:55 a.m. when he had scooted out of the recliner. No injury was noted and the nurse practitioner (NP) noted R49 was acting out of character so ordered a PRN (as needed) dose of Haldol (an antipsychotic medication). R49 went to the emergency room and returned without new orders. R49 was being treated for an abscessed tooth (7/5/14). The DON stated R49 was sleepy because he had been awake most of the night. On 7/10/14, R49 was sleeping in the Broda chair in the day room, unable to arouse when spoken to at 9:17 a.m.. At 9:33 a.m. R49 was brought to his room by a trained medication aide (TMA)-A and NA-D. TMA-A stated R49 had been lethargic recently, and they were using the mechanical lift when he was not able to assist with a stand assist lift. TMA-A further stated R49 had been in a really bad place lately, he was unable to communicate his needs, and was unable to comprehend when staff spoke to him. NA-D stated R49 appeared antsy and had lots of body movements. At 10:44 a.m. R49 was in bed sleeping. At 1:55 p.m. R49 was observed in the day room sleeping in the Broda chair. On 7/10/14, at 12:49 p.m. the DON was interviewed and stated falls were discussed every morning at the interdisciplinary team (IDT) meetings. The IDT does a root cause analysis on the falls, reviews current interventions and	F 323		

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F 323	Continued From page 29 considers additional interventions. The documentation from the IDT meetings was not part of the medical record and did not include assessments to determine appropriate interventions. The facility policy and procedure on resident incident report and investigation dated 3/10, directed an investigation to determine the cause of the fall/incident and to prevent the same incident from recurring. The facility policy and procedure on fall risk profile dated 4/4/12, directed the IDT to individually report interventions and follow-up as well as to update the care plan with new interventions as needed. The immediate jeopardy that began on 5/23/14, and identified on 7/10/14, was removed on 7/12/14, at 3:47 p.m. when the facility completed a comprehensive fall risk assessment for R49, added new safety interventions, updated the care plan and provided staff education. R49's recliner and wheelchair were removed from the room, he had been assessed for safe use of the Broda chair, and was placed on 15 minute checks. Nursing staff were to provide 1:1 supervision if R49 was demonstrating signs restlessness or anxiety, the bed was placed in the low position, and a mat was put along side of the bed when R49 was in bed. Non-compliance remained at the lower scope and severity of a G, which indicated actual harm that was not immediate jeopardy. R39 had multiple falls without assessment of potential causative factors or consideration of appropriate interventions to reduce the risk and frequency of falls.	F 323		

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	245374	A. BUILDING _____ B. WING _____	07/15/2014

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F 323	Continued From page 30 R39's Admission Record dated 9/17/12, identified diagnoses that included cerebral vascular disease, congestive heart failure, peripheral vascular disease, depression and rheumatoid arthritis. R39's care plan indicated a history of cerebral vascular accident (CVA, commonly known as stroke). The quarterly MDS dated 6/10/14, indicated R39 was cognitively intact and had no behaviors. The MDS further identified R39 as requiring extensive assistance of one staff for bed mobility, transfers, ambulation and toileting, R39 was identified as being frequently incontinent of bladder, and had 2 or more falls since the previous MDS, with no injury. R39's fall risk assessment was a checklist dated 6/10/14, and indicated high risk for falls. R39 had three falls in the quarter due to self transfers, labile mood, turning off personal alarms, and impulsive behaviors. Interventions included staff to monitor behaviors, assist with transfers, offer ambulation, provide one-to-one time, and allow to vent. Other interventions included the call light within reach at all times, toilet every one to two hours, mats on the floor, and monitor for safety issues. R39's care plan revised 10/20/12, indicated a risk for falls related to CVA, confusion and PRN psychotropic medications use. The goal was for R39 to be free of falls. The care plan identified the following interventions: personal alarms on at all times, seat alarm on while sitting in the recliner and bed and sensor alarm on while in bed, monitor for safety issues, provide assist with all mobility, remind to use call light, and provide increased assistance with transfers and ambulation if weak or increased unsteadiness.	F 323		

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F 323	Continued From page 31 R39's fall reports indicated the following: *On 1/22/14, at 5:05 a.m. R39's alarm was sounding and he was found with his leg on the floor and the upper half of his body on the bed. R39 was unable to state what happened. No injury was noted. Interventions to prevent recurrence were alarms reset per protocol, mat in place beside bed, and use of call light for assistance. The 24 hour follow up indicated no injury noted, safety protocols being followed. *On 1/27/14, at 7:14 p.m. R39 fell while being assisted by one staff with transfers. R39 received a small scrape to the left elbow. Interventions to prevent the incident from reoccurring were staff reminded to use assist of two when needed. The 24 hour follow up indicated no further incidents. *On 5/1/14, at 1:40 p.m. R39 was found on floor at bedside, having removed the personal alarm. No injury was noted. Interventions to prevent recurrence were not suggested. The fall was documented as an isolated incident. R39 stated he had unclipped the alarm. The 24 hour follow up indicated no further incidents. *On 5/23/14, at 10:30 p.m. R39's alarm was sounding, and he was found on the floor by bed, unable to state what happened. No injury was noted. Interventions prevent recurrence were to continue fall precautions and increased vigilance. The 24 hour follow up indicated no apparent injuries and continue to monitor. *On 5/29/14, at 6:00 a.m. R39's alarm was sounding and staff found him on the floor at the foot of the recliner with no injuries. Interventions to prevent recurrence were to remind resident to	F 323		

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F 323	Continued From page 32 use call light and wait for staff assist. The 24 hour follow up indicated no further incidents. *On 6/18/14, at 4:54 a.m. R39's alarm was sounding and staff found him on the floor at the foot of the recliner. R39 stated he was trying to get up to change clothes and had removed the personal alarm. No injury was noted. Interventions to prevent recurrence were to remind R39 to use call light for help, not try to get up on own and alarms. On 7/9/14, at 12:55 p.m. R39 was observed to transfer from the wheelchair to the recliner with trained medication assistant (TMA)-A and nursing assistant (NA)-D. TMA-A and NA-D placed transfer belt around R39, locked the wheelchair brakes, and explained to R39 what they were going to do. R39 was able to bear weight, and was transferred into the recliner. The personal alarm was in place. R48 was observed to have a fading yellow bruise on the right upper forehead on 7/8/14, at 9:52 a.m.. R48's face sheet and physician order sheet dated 6/5/14, indicated diagnoses included memory loss, dementia, paralysis agitans (Parkinson's) and history of falls. The significant change MDS dated 5/12/14, indicated R48 had severe cognitive impairment and required total assist of two staff for bed mobility and transfers. Assistance of one staff was required for dressing, bathing and personal hygiene. The MDS indicated R48 had no falls in the past six months.	F 323		

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F 323	Continued From page 33 The Care Area Assessment (CAA) for skin dated 5/13/14, addressed R48's risk for skin breakdown, but did not address bruising. R48's care plan dated 5/8/14, addressed dependencies for activities of daily living (ADLs), cognitive impairment, safety regarding falls, and skin integrity regarding pressure ulcers. The care plan did not indicate R48 had problems with bruising. The MDS charting in nursing progress notes dated 5/11/14, at 6:25 p.m. indicated R48's skin was dry and intact at that time. The MDS charting further indicated R48 was unable to communicate wants and needs to staff, required complete staff assistance with all bed mobility and personal hygiene, and had no behavior incidents within the assessment period with the exception of infrequent resistance to medications. The nursing progress notes dated 5/31/14, at 2:04 p.m. indicated R48 had a yellow bruise measuring 2 cm round on the right side of forehead. No pain was expressed when area was touched. The nursing progress notes dated 6/16/14, at 10:47 p.m. indicated R48 rolled over too far and bumped the front of his head on the wall during personal hygiene cares. R48 stated, "Ow!" Documentation indicated R48 had no bruising or bump at that time and had no further complaints of pain. During observations of morning care on 7/9/14, at 7:43 a.m. R48's bed was against the wall on the right side. NA-A provided repositioning, personal hygiene, incontinence care, dressing and oral care all from the outside of the bed, placing R48 at risk of repeated falling into the wall. R48 did	F 323		

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F 323	Continued From page 34 not participate in any way with repositioning or care. The care plan directed assistance of two staff for bed mobility that would include repositioning in bed. Licensed practical nurse (LPN)-A, interviewed on 7/10/14, at 9:45 a.m., stated the bruise found on 5/31/14, had been investigated and there should be an incident report. LPN-A stated bruises of unknown source were investigated by interviewing all staff working at the time. LPN-A was unaware of the incident on 6/16/14, when R48 was turned into the wall and hit his head. LPN-A verified there was no documentation other than a nursing note describing the bruise. During an interview on 7/15/14, at 9:27 a.m. NA-D stated R48 did not move in bed on his own. NA-D stated she assumed R48 hit his head on the wall when turned in bed about a month ago when there was a bruise on his head that nobody knew what caused it. The policy and procedure for resident incident report and investigation form revised 3/10, directed when an incident/fall occurs, it must be reported as soon as possible by completing the resident incident report and investigation form and examples of incidents includes bruises and skin tears. The policy further directed an investigation must be completed to determine the cause of the incident and to prevent the same incident from occurring, and the family is to be notified of all incidents.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on	F 356		8/25/14

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F 356	Continued From page 35 a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the daily Nursing Hours posting was accurate and updated throughout each day, included the actual hours worked by licensed and unlicensed staff on each shift. This has the potential to affect all 29 of 29 residents in the facility.	F 356	Policy has been written on Nurse staffing posting. Sheet used for posting has been revised to reflect the actual hours worked by staff. The staff who fill this out were verbally educated regarding new sheet the week of July 28th. All nurses/tmas will be educated in person at nurse□s	

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F 356	Continued From page 36 Findings include: On 7/7/14, at approximately 2:30 p.m. during the initial facility tour, the Nursing Hours posting on second floor, lacked the actual hours worked by licensed and unlicensed staff on each shift. Daily postings from 6/25/14 through 7/9/14, lacked the actual hours worked by licensed and unlicensed staff on each shift. The comparison of the nursing schedule to the daily postings from 6/25/14 through 7/9/14, indicated there were inaccuracies in the posting on 6/27/14, 6/28/14, 6/29/14, 6/30/14, 7/1/14, 7/3/14, and 7/9/14. The number of staff on the schedule was not the same as the number of staff on the posting. On 7/15/14, at 1:19 p.m. the director of nursing (DON) stated the night nurse does the postings each day. DON verified they did not make adjustments to the posting during the day, and they did not put the actual hours worked by staff on the posting.	F 356	meetings on 08/13/14 and 08/14/14 regarding the new policy and procedure. The DON, ADON, or her designee will complete weekly audits until compliance is reached and quarterly thereafter or as needed. The results of such audits will be reviewed by the DON and thereafter take any necessary actions. Results of such audits will be reported to facility Quality Assurance Committee and Committee will make further recommendations regarding ongoing audits. DON, in conjunction with the ADON, to monitor and assure compliance. Completion date: 08/25/14.	
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		8/25/14

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F 371	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff used utensils while feeding a resident for 1 of 10 residents (R10) observed in the dining room. Findings include: R10 was observed on 7/7/14, at 4:27 p.m. and nursing assistant (NA)-B used bare hands to assist with eating a sandwich. The significant change Minimum Data Set (MDS) dated 6/25/14, indicated R10 had a severe cognitive loss, was dependent of one staff for eating, and had a diagnosis of Alzheimer's dementia. The Care Area Assessment (CAA) for pain dated 6/27/14, indicated R10 received hospice services for end stage dementia and was dependent on one to two staff for all activities of daily living (ADLs). On 7/7/14, at 7:06 p.m. NA-B verified R10 was fed using bare hands and stated that was his usual practice. On 7/10/14, at 2:18 p.m. DON verified when feeding a dependent resident a sandwich, staff should use a fork, spoon or glove to feed the resident and should not use bare hands. The facility's undated Single-Use Gloves policy and procedure directed dietary staff would not have direct hand or arm contact with exposed, ready-to-eat food when utensils could be used. The policy did not address direct care staff. The Assisting With Resident's Meals policy and	F 371	Staff member (NA-B) who touched the Resident□s sandwich with a bare hand was counseled/re-educated on 7/16/14. Assisting with Resident□s Meals policy and procedure has been reviewed and revised to include the statement staff should not come in direct contact with food. Use utensils or gloves. All staff were re-educated regarding this at inservice on 07/31/14. The ADON, DON, or her designee will complete weekly audits until compliance is reached and quarterly thereafter or as needed. The results of such audits will be reviewed by the DON and thereafter take any necessary actions. The results of such audits will be reported to facility Quality Assurance Committee and Committee will make further recommendations regarding ongoing audits. DON, in conjunction with the ADON, to monitor and assure compliance. Completion date: 08/25/14. The ceiling tile in the dry storage room that was stained was replaced on 07/10/14. Checking ceiling tiles for stains in the dry storage room will be added to the Food Safety and Sanitation checklist that is completed monthly by Dietary Supervisor. Results of the checklist will be reported to the Administrator or his designee. Administrator, in conjunction with Dietary Supervisor, to monitor for compliance.	

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F 371	Continued From page 38 procedure dated as revised on 4/4/12, provided guidelines for feeding dependent residents, but lacked direction regarding staff providing feeding assistance using bare hands. During a tour of the kitchen on 7/9/14, at 1:50 p.m. the ceiling tiles in the dry food storage room were stained with brown irregular shaped rings. The dietary supervisor stated there had been no dripping onto the food and stated she had not previously noticed the stains on the tiles. The dietary supervisor stated they do environmental walk throughs and verified the staining on the ceiling tiles should have been noticed and changed.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		8/25/14

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F 441	Continued From page 39 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hygiene and gloving practices were implemented during activity of daily living (ADL) cares for 1 of 3 residents (R48) reviewed for ADLs. Findings include: R48's Admission Record and physician's order sheet dated 6/5/14, identified diagnoses to include memory loss, dementia, paralysis agitans (Parkinson's), and history of falls. The significant change Minimum Data Set (MDS) dated 5/12/14, indicated R48 had severe cognitive impairments and required total assist of two staff for bed mobility, transfers, and toileting, and required total assist of one staff for locomotion in a wheelchair, dressing, bathing and personal hygiene, and extensive assist with	F 441	CNA who did not follow proper hand hygiene while providing perineal care was counseled/re-educated on 07/09/14. (NA-A). All staff were re-educated on this at inservice on 07/31/14. The DON, ADON, or her designee will complete weekly audits(that consist of direct observation) until compliance is reached and quarterly thereafter or as needed. The results of such audits will be reviewed by the DON and thereafter take any necessary actions. The results of such audits will be reported to the facility Quality Assurance Committee and Committee will make further recommendations regarding ongoing audits. DON, in conjunction with the ADON, to monitor and assure compliance. Completion date: 08/25/14.	

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F 441	Continued From page 40 eating. R48's care plan dated as revised on 5/8/14, indicated R48 was physically dependent on one staff for assistance with dressing, personal hygiene, as well as pericares and brief changes. On 7/9/14, at 7:43 a.m. nursing assistant (NA)-A was observed providing cares for R48's ADLs. NA-A was observed to remove gloves after removing R48's soiled incontinent brief, put on clean gloves and used wipes to complete cleansing R48's buttocks. NA-A removed the soiled gloves and put on clean gloves to put powder on R48's trunk, then turned R48 to his back, used wipes to clean stool from R48's left outer leg, turned R48 on his left side, wiped his buttocks and rectal area, and applied barrier cream to his buttocks. Continuing with the same gloves, NA-A put a clean incontinent pad on and removed gloves. R48 was covered and NA-A washed hands in the bathroom before completing cares. On 7/10/14, at 2:18 p.m. the director of nursing (DON) stated gloves should be changed between dirty and clean, before the clean pads were touched, and further stated if the resident can safely be left, then the NA should wash hands between glove changes. The facility's Hand Hygiene policy and procedure dated as revised on 10/25/10, directed hand hygiene must be done with soap and water following contact with contaminated areas or materials, and with alcohol based hand sanitizer or soap and water before applying and after removing gloves, and anytime moving from one task to another.	F 441		

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F 441	Continued From page 41 The Resident AM/PM Cares-Using Ready Bath Basics Total Body Cleansing System policy and procedure dated as effective on 3/11/13, directed staff to remove gloves and wash hands after cleansing perineum and when stool present, and then put on a new pair of gloves and apply lotion.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain 7 of 21 resident rooms reviewed (#s125, 107, 251, 111, 230, 224, 203) related to scrapes on the room furniture, doors and walls, bathrooms and stains on the ceiling tiles in the facility's kitchen. In addition, the hand rails in the 2C hall were chipped, marred and loose, 2 of 2 easy stands were soiled, a resident food refrigerator was soiled, not in good repair and not functioning properly. The first floor refrigerator and kitchen ceiling tiles were not clean. Findings include: On 7/10/14, at 9:10 a.m. during an environmental tour done with the housekeeping supervisor (HS) the following was noted: The bathroom door frame in room 125 was	F 465	All items identified in the survey have been repaired as of 08/06/14. First floor refrigerator was replaced on 07/09/14. New Unit Refrigerator policy and procedure was written on 08/07/14. Dietary and Housekeeping staff educated verbally and in writing starting on 08/07/14. Mechanical Lift including standing plate was cleaned on 07/10/14. Non skid tape on standing plate was repaired on 07/10/14. Both mechanical lift policies were reviewed and revised on 08/07/14 to include cleaning procedures. Cleaning of mechanical lifts has been added to a schedule to be completed by Environmental Services. Staff educated verbally and in writing. The Environmental services Supervisor or her designee will complete weekly audits until compliance is reached and quarterly thereafter or as	8/25/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	07/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MEDICAL CENTER	129 EAST 6TH AVENUE PINE CITY, MN 55063

(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 465	Continued From page 42 scraped and had chips in the paint. The bathroom door frames were chipped and scraped in room 107. A built in dresser drawer was gouged with a strip of wood missing and had sharp edges. In room 251 the ceiling tile above the bed had an approximately six inch circular brown spot. The inside of the bathroom door at the bottom had long scraped areas exposing rough wood. In room 111 the bathroom door frame was chipped and scraped. The dresser next to the bed in room 230 was marred and missing the knob on the top drawer and the handle on the bottom drawer. The bathroom hot water faucet handle was broken off. The dresser was marred and scratched in room 224. Room 203 had a ceiling tile with a brown stain. The standing plate on the easy lift (mechanical standing lift) on the first floor was soiled with loose and ground in food crumbs. The standing plate on the easy lift on the second floor was soiled with crumbs and the nonskid tape was loose and lifted up. In the 2C hall; the wood hand rail on both sides and the entire length of the hall had numerous scrapes and rough areas. The handrail between rooms 248 and 249 was loose. The HS stated a "walk through" of the facility was done weekly by various staff to ensure it was not	F 465	needed. The results of such audits will be reviewed by the Administrator or his designee and thereafter take any necessary actions. The results of such audits will be reported to facility Quality Assurance Committee and Committee will make further recommendations regarding ongoing audits. Environmental Services Supervisor, in conjunction with the Administrator to monitor and assure compliance. Completion date: 08/25/14. A checklist was added to the Environmental walk through process to insure Resident rooms are checked for gouges in furniture, any scrapes in paint on door frames, ceiling tiles that need replacement, or any other repairs. All staff was re-educated at the 07/31/14 inservice to place any items in need of repair on the maintenance board so they can be repaired. All Resident rooms were inspected the week of July 21st and needed repairs are either repaired or in progress. Completion date: 08/25/14.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	07/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MEDICAL CENTER	129 EAST 6TH AVENUE PINE CITY, MN 55063

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F 465	Continued From page 43 done by the same person. The HS stated there was not a checklist, but notes were taken. For maintenance repairs, each unit had an environmental services clipboard where staff can write areas needing repairs. There was no mechanical lift cleaning schedule, the lifts were cleaned as needed. The facility's Preventive Maintenance Program policy dated as reviewed on 5/8/14, indicated the facility would provide maintenance of equipment, building and grounds. The preventive maintenance program would ensure equipment was repaired, operative and the interior and exterior of the building was clean, orderly and in good repair. The purpose of the policy was to ensure all essential mechanical, electrical and resident care equipment and the facility would be maintained in a safe, operative and home like condition. On 7/9/14, at 8:36 a.m. the first floor refrigerator that contained resident food was observed to have uncleanable areas with cracked and broken corners of the door shelves and with evidence of liquids having dripped and collected in these areas.	F 465		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514		8/25/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	07/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MEDICAL CENTER	129 EAST 6TH AVENUE PINE CITY, MN 55063

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F 514	Continued From page 44 resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure clinical documentation was timely and complete for 5 of 5 residents (R70, R61, R69, R9, R71) reviewed for discharge. Findings include: R70's clinical record was incomplete. Progress notes revealed R70 was admitted on 6/1/14, for therapy following a fall with resulting cervical fracture, confusion and forehead contusion. R70 was discharged to home with his family on 6/12/14. Record review for R70 revealed the last progress note entered was regarding a fall at 3:50 a.m. on 6/12/14. The entry made at 4:37 a.m. indicated R70 was found on his back at the foot of his bed. The wheelchair was tipped over next to him. The documentation revealed there were no apparent injuries and R70 had adequate range of motion (ROM). However, although R70 was admitted with falls and a cervical fracture, neurological functioning was not assessed. There were no further entries in the record related to R70's status after the fall or his discharge home later in the day. R61 did not have a comprehensive clinical record. R61 was admitted on 4/25/14, for therapy	F 514	Health Information Record policy and procedure was reviewed and revised on 08/04/14 to clarify the discharge summary requirements. The Health Care provider (NP, MD) will complete a discharge summary on all Residents who leave the facility besides in the case of a Resident death, in which case the death certificate will suffice. The nursing staff will make a discharge nurses note on all Residents who are discharged from the facility to home, assisted living, or other community based living arrangement. A template was devised to assist Nursing staff in including the needed elements in the discharge note. The discharge instruction sheet has been reviewed and revised on 08/04/14 to include a spot for discharging nurse to mark that she made a discharge note. New policy and procedure has been written on resident discharges to serve as a written guide for the nurse to reference if needed. All licensed staff will be educated in person at nurse s meetings on 08/13/14 and 08/14/14 regarding the above. Health Information dept will audit charts for presence of nursing discharge note. R70: Neurological assessment and Resident fall/found on floor policy and procedure has been reviewed and revised	

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	245374	A. BUILDING _____ B. WING _____	07/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 45 following a total knee arthroplasty. Therapy notes indicated R61 went home with his wife on 5/8/14. Nursing progress notes revealed the last entry completed was on 5/7/14, written at 7:17 p.m. The note indicated R61 was independent with cares, ambulated with a walker and was happy to be going home tomorrow. There was no further documentation regarding R61 up to and including his discharge from the facility. R69's Admission Record indicated R69 was admitted to the facility on 5/31/14, and with diagnoses to include knee joint replacement and aftercare following joint replacement. R69 received physical therapy (PT) and occupational therapy (OT) during the stay at the facility. R69 was discharged from the facility on 6/11/14. R69's clinical record lacked a discharge planning note, lacked a discharge summary which included a recapitulation of stay and lacked documentation where R69 was discharged to. On 7/10/14, at 12:41 p.m. the director of nursing (DON) stated she would expect the discharging nurse to complete a discharge summary on all residents who were discharged, transferred or died. DON further stated this note should include where the resident was discharged to, review of medications and orders with the resident and/or family (if the resident discharged or was transferred out of the facility). R9's Admission Record dated 4/12/14, indicated R9's diagnoses included congestive heart failure, chronic airway obstruction, oxygen dependence, atrial fibrillation and heart disease. R9 received physical and occupational therapy. R9 died while at the facility on 6/12/14. There was no discharge summary completed. R71's Admission Record dated 6/6/14, indicated	F 514	to include that any resident who has an unwitnessed fall will have neurological assessments done. The incident and accident report was updated to prompt licensed staff to do neurological assessments after unwitnessed fall. Nurses have been educated to this either verbally or in writing and will be re-educated regarding documentation requirements to be completed after a fall at nurse□s meeting on 08/13/14 and 08/14/14. The ADON, DON, or her designee will complete weekly audits until compliance is reached and quarterly thereafter or as needed. The results of such audits will be reviewed by the DON and thereafter take any necessary actions. The results of such audits will be reporting to the facility Quality Assurance Committee and Committee will make further recommendations regarding ongoing audits. DON, in conjunction with the ADON, to monitor and assure compliance. Completion date 08/25/14	

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	245374	A. BUILDING _____ B. WING _____	07/15/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MEDICAL CENTER	129 EAST 6TH AVENUE PINE CITY, MN 55063

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F 514	Continued From page 46 R71's diagnoses included aftercare following back surgery. R71 received physical and occupational therapy and was discharged home on 6/13/14. The medical record did not include a discharge summary. The facility's Health Information Record policy dated as reviewed on 2/12/14, indicated a discharge summary was to be completed by 30 days after discharge from the facility. The policy indicated the summary would include: the reason for the stay, a summary of clinical observations, procedures performed, treatments received, pertinent laboratory, x-ray and test results. Condition and discharge diagnosis of the resident at discharge or if the resident died; the cause of the death. On 7/10/14, at 12:41 p.m. DON confirmed there was no discharge information for R9, R61, R69, R70, and R71.	F 514		

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

F5374023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/08/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE MEDICAL CENTER	**129 EAST 6TH AVENUE** **PINE CITY, MN 55063**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Lakeside Medical Center C & NC was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Lakeside Medical Center C & NC is a 1-story building with a full basement. The original building was constructed in 1966 with an addition constructed in 1971. The 1966 building is of type II(111) construction and the 1971 building is type II(111) construction. Therefore, the nursing home was inspected as one building. The facility has a small hospital and clinic, attached, and they are properly separated from the nursing home. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 46 beds and had a census of 30 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
July 31, 2014

Mr. Max Blaufuss, Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, Minnesota 55063

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5374023

Dear Mr. Blaufuss:

The above facility was surveyed on July 7, 2014 through July 15, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Patricia Halverson by email at: Patricia.Halverson@state.mn.us or phone at (218) 302-6151.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Original - Facility
Licensing and Certification File