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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IBO1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00360

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245280**
2.STATE VENDOR OR MEDICAID NO.
(L2) **285042700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKEVIEW METHODIST HEALTH CARE CENTER**
(L4) **610 SUMMIT DRIVE**
(L5) **FAIRMONT, MN** (L6) **56031**

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 **06/19/2015** (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 **85** (L18)

13.Total Certified Beds **85** (L17)

10.THE FACILITY IS CERTIFIED AS:
X 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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 06/22/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/22/2015 (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
06/01/1985
(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 06/30/2015 Co / RePosted
DETERMINATION APPROVAL

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/08/2015
(L33)

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245280

June 22, 2015

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, Minnesota 56031

Dear Ms. Barnes:

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 May 14, 2015 the above facility is certified for:

85 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 85 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.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 22, 2015

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, Minnesota 56031

RE: Project Number S5280024

Dear Ms. Barnes:

On May 4, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 16, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 19, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 16, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 14, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 16, 2015, effective May 14, 2015 and therefore remedies outlined in our letter to you dated May 4, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245280	A. Building B. Wing	6/19/2015

Name of Facility	Street Address, City, State, Zip Code
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

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 **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **05/14/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **05/14/2015**	ID Prefix **F0242** Reg. # **483.15(b)** LSC	Correction Completed **05/14/2015**
ID Prefix **F0258** Reg. # **483.15(h)(7)** LSC	Correction Completed **05/14/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **05/14/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/14/2015**
ID Prefix **F0313** Reg. # **483.25(b)** LSC	Correction Completed **05/14/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **05/14/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **05/14/2015**
ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **05/14/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **05/14/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/14/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **05/14/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **05/14/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **05/14/2015**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GPN/ kfd	06/22/2015	31767	06/19/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245280	A. Building B. Wing	6/19/2015

Name of Facility	Street Address, City, State, Zip Code
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

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 **F0441** Reg. # **483.65** LSC	Correction Completed **05/14/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **05/14/2015**		

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GPN/ kfd	06/22/2015	31767	06/19/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/16/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00360	A. Building B. Wing	6/19/2015

Name of Facility	Street Address, City, State, Zip Code
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

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 **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **06/19/2015**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **06/19/2015**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **06/19/2015**
ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **06/19/2015**	ID Prefix **20930** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **06/19/2015**	ID Prefix **20965** Reg. # **MN Rule 4658.0600 Subp.** LSC	Correction Completed **06/19/2015**
ID Prefix **21025** Reg. # **MN Rule 4658.0615** LSC	Correction Completed **06/19/2015**	ID Prefix **21134** Reg. # **MN RULE 4658.0670 Supb** LSC	Correction Completed **06/19/2015**	ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp.** LSC	Correction Completed **06/19/2015**
ID Prefix **21395** Reg. # **MN Rule 4658.0805** LSC	Correction Completed **06/19/2015**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Su** LSC	Correction Completed **06/19/2015**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **06/19/2015**
ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp.** LSC	Correction Completed **06/19/2015**	ID Prefix **21620** Reg. # **MN Rule 4658.1345** LSC	Correction Completed **06/19/2015**	ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **06/19/2015**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GPN/kfd	06/22/2015	31767	06/19/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00360	A. Building B. Wing	6/19/2015

Name of Facility	Street Address, City, State, Zip Code
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

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 **21805** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **06/19/2015**	ID Prefix **21880** Reg. # **MN St. Statute 144.651 Sul** LSC	Correction Completed **06/19/2015**		

Reviewed By _____ **State Agency**	**Reviewed By** GPN/kfd	**Date:** 06/22/2015	**Signature of Surveyor:** 31767	**Date:** 06/19/2015
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/16/2015

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: IBO1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00360

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245280**
2.STATE VENDOR OR MEDICAID NO.
(L2) **285042700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKEVIEW METHODIST HEALTH CARE CENTER**
(L4) **610 SUMMIT DRIVE**
(L5) **FAIRMONT, MN** (L6) **56031**

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 **04/16/2015** (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 **85** (L18)

13.Total Certified Beds **85** (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
	85			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gail Sorensen, HFE NE II 05/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/03/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 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
06/01/1985
(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

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 4, 2015

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, Minnesota 56031

RE: Project Number S5280024

Dear Ms. Barnes:

On April 16, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 26, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 26, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 16, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 16, 2015 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure unresolved grievances were acted on for 2 of 2 residents (R13, R97) reviewed who had voiced concerns with the facility staff. Findings include: R13's quarterly Minimum Data Set (MDS), dated 1/7/15, identified R13 had intact cognition. During an observation and interview on 4/13/15, at 6:16 p.m. R13 stated she had asked to be	F 166	Resident R 13 has an extensive history of stealing belongings from residents and the facility. Currently she resides in the room next to the floor supervisor□s office for monitoring purposes. Previously has been offered other rooms throughout the facility but has declined. On 5/5/15 social services approached R 13 and offered to show her other rooms in the facility that she may wish to move to, in which she initially declined, and after encouragement she agreed to look at the lakeside view rooms. She declined to make any	5/14/15

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

Electronically Signed | 05/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 166	Continued From page 1 moved to a different room since she admitted to the facility, because her current room overlooked a rooftop with heating and cooling equipment. Further, R13 said, "I keep the curtains closed, because their is nothing to see." R13's curtains were closed, and secured together with a wooden clothes pin during the interview. When curtains were opened her outside view included several exhaust fans, pipes, and heating/cooling equipment was visible. When interviewed on 4/16/15, at 11:40 a.m. the licensed social worker (LSW)-A stated R13 had mentioned before that she did not like her room as their was "pipes outside the window." The interdisciplinary team had discussed moving her, but decided not to because they felt R13 likely still wouldn't be satisfied. Further, R13 had been shown one different room months ago, but declined to move. R13's Social Services Progress Note, dated 8/5/14, read, "...resident stated she would like a room with a view here at Lakeview." Further, "Res [resident] viewed a room on West wing, 3rd floor to see if this style of room and view would please resident. Resident stated she was still looking at a roof. Resident was informed she would be considered as rooms became available." During a subsequent interview on 4/16/15, at 2:58 p.m. LSW-A stated she had not shown R13 any more rooms since 9/25/14, as R13 often naps during the day. R13 was on the waiting list for assisted living, but added, "I supposed I could show her another room." Further, LSW-A stated if a resident had a concern with their room it would be addressed "most of the time", and, "I	F 166	decisions at this time, and stated she will contact social services once she is ready and has made her decision. Social service will follow up weekly with Resident R 13 to see if she is ready to make a decision and document accordingly. Resident R97 did not have hearing aids in place at time of survey. R 97 prefers to keep her own hearing aids in her room and staff is to place them with morning cares. Signs have been placed in resident□s room, education in floor communication book, and placement on MAR to be checked and signed off, this education was done by Director of Nursing on 4/17/15. Going forward the hearing aid placement will be a designated task within our Point Click Care, EMR system. This will allow for an alert to make sure the hearing aids are placed. Staff was educated per our facility grievance policy (SS065) to fill out the grievance policy form and turn into social services for timely follow up of grievance and new forms were made available effective 5/14/15. Policy and procedure for grievance updated stating that Grievances will be reviewed at morning stand-up meeting with IDT and follow up and education provided with involved staff. Audits will be performed by social service for residents who have filed a grievance monthly. Social service will follow up with R 13 and R97 weekly to assure no further issues have arisen. Director of Nursing provided reeducation material to all staff, effective date of correction 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 166	Continued From page 2 feel she [R13] is fine in that room." A facility Grievance policy, dated 9/8/10, identified, "It is our policy to address concerns of grievances in a timely manner", and, "Within 48 hours (Monday through Friday) of receiving the concern or grievance, the resident or family member will be contacted regarding follow up." R97's quarterly Minimum Data Set (MDS) dated 3/4/15 indicated R97's ability to hear was adequate with the use of a hearing aid. R97's care plan, dated 03/15/13, read, "...Resident is able to communicate needs ...hearing is adequate with the use of bilat [bilateral] aides." In addition it directed staff to place hearing aids daily in the morning and the nurse was to check to ensure they were functioning properly and batteries were working. On 4/13/15 at 7:12 p.m. during an interview with R97 and her friend (FR)-A present, R97 was observed to not have her bilateral hearing aids in place. FR-A stated R97's bilateral hearing aids are often not in when she comes to visit her. FR-A stated she had shared this concern with the facility staff on multiple occasions. FR-A proceeded to assist R97 with placing her hearing aids and told surveyor R97 would be able to hear the questions better now that she had her hearing aids in place. On 4/16/15 at 9:30 a.m. R97 was observed to be sitting in her recliner in her room reading the newspaper and her hearing aides had not been placed. On 4/16/15 at 9:32 a.m. licensed practical nurse (LPN)-H stated the nursing assistant who	F 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 166	Continued From page 3 assisted R97 with morning cares was responsible for placing R97's hearing aids for the day. LPN-H stated she was unaware R97's hearing aids not being placed was a concern for R97 and FR-A. On 4/16/2015 9:38 a.m. during an observation LPN-H verified R97 did not have her hearings hearing in her ears and asked R97 if she would like to have her hearing aids placed in her ears and R97 stated "yes". LPN-H placed resident's hearing aids and R97 thanked her. On 4/16/2015 at 10:03 a.m. social services (SS)-D stated FR-A had voiced a concern to her regarding R97's hearing aids not being placed. SS-D stated she communicated this concern to the nursing department at a morning stand up meeting for follow-up to ensure R97's hearing aids were being placed daily. SS-D stated there was no further social service follow-up regarding this concern. SS-D stated her expectation was when staff was getting residents ready for the day their hearing aids should be placed. SS-D stated concerns are made into grievances right away and stated she would check her file to see if a grievance was filed regarding the concerns with R97's hearing aids. SS-D stated a grievance should have been filed regarding the concern hearing aids not been placed. On 4/16/15 at 11:23 a.m. SS-D stated she was unable to find a grievance form regarding R97's hearing aids not being placed. SS-D stated depending on what the concerns was, determined whether or not she would initiate a concern/grievance form. SS-D stated the hearings aides would have been an issue nursing could have easily followed up on to ensure they were placed and this was why a grievance was	F 166		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 166	Continued From page 4 not completed for this concern. The grievances policy and procedure dated 2010 read, " When a concern is brought to a staff member ' s attention the following steps will be taken. 1. Complete the facility's grievance form: provide as much detail as possible. 2. Immediately route the original copy to the appropriate department in the identified in the concern. Make a copy for all other departments affected by the concern (i.e. nursing, dietary, laundry, etc.). 3. Within 24 hours (Monday through Friday), the original should be returned to the Social Service office with the follow up section completed. 4. Social Services will notify the administrator of the grievance. 5. Based on the concern, the appropriate departments will meet to determine the necessary response and what department will follow up with the resident or the follow up with the resident or family member. 6. Within 48 hours (Monday through Friday) of receiving the concern or grievance, the resident or family member will be contacted regarding the follow-up. "	F 166		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by:	F 241		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 241	Continued From page 5 Based on observation, interview and record review, the facility failed to provide a dignified dining experience on the 3rd floor west dining room for 4 of 4 residents (R3, R83, R33 and R6) who were seated together during their dining experience. Findings include: R3, R83, R33 and R6 all dependent on staff to eat their meal were observed during observations on 4/13/15 at 5:07 p.m., on 4/14/15 at 9:05 a.m. and 4/16/15 at 11:45 p.m. located on the third floor west dining room also referred to by staff as the " feeder dining room." It was observed that the tables in this dining area did not have placemats or table center pieces and the resident ' s food was left on the serving trays while residents were assisted to eat. However, the independent dining room had fresh flowers and placemats on the tables also the resident ' s meals were delivered to the residents on serving trays and the meal was removed from the serving trays. R3 was observed on 4/13/15, at 5:11 p.m. when nursing assistant (NA)-E donned a clothing protector on R3; NA-E did not give R3 the choice if she wanted the clothing protector on and NA-E did not inform R3 the clothing protector was going to be applied. R83 was observed on 4/13/15; at 5:15 p.m. NA-E placed a meal serving tray off to the side of R83. NA-E did not uncover the meal for the resident and left the room. R83 then attempted to grab the silverware off of the tray. At 5:17 NA-E returned, uncovered the meal, cut up the sandwich, and left the dining room again.	F 241	Facility failed to provide a dignified dining experience on the 3rd floor west dining room for 4 of 4 Residents (R3, R83, R33 and R6). Facility integrated the four residents into the 3rd floor dining room with general population so all staff will be present to assist residents with meals on 4/28/15. All staff were reeducated by dietary director on 4/28/15 in regards to removing the plates from the serving trays, and offering clothing protectors to all residents. Dietary manager reeducated on timely assistance with meals, proper hand washing between residents during but not limited to meal times, and facility policy regarding dining room experience. Facility has initiated a QUAPI in regards to resident dining room experience. Certified Nurse Aid will audit dining room daily. Nursing supervisor will appoint one person daily to perform these dining room audits on dining experience and will be turned into QA committee. Director of Nursing has provided reeducation material to all staff, effective date of correction 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 241	Continued From page 6	F 241		

R33 was observed on 4/13/15; at 5:16 p.m. NA-E removed R33 from the table and took R33 out of the dining room per a licensed nurse request. R33's tray was placed on the table at 5:19 p.m. R33 returned to the dining room at 5:20.

R6 was observed on 4/13/15, at 5:19 p.m. NA-F placed meal tray in front of R6 who was still sleeping since the start of meal service. NA-F then uncovered the food tray that contained pureed cold ham sandwich, pureed cooked carrots, and pureed mashed potatoes. Then NA-F walked away from the table. NA-F did not attempt to awake R6 until 5:27 p.m.; this attempt to arouse R6 was not successful. NA-F did not attempt to awake R6 again until 5:49 p.m. R6's food had remained uncovered for 30 minutes. NA-F did not take the temperature of the food prior to assisting R6 to eat. R6. NA-F stood next to R6 and gave bites of food items mixed together on the spoon.

Throughout the majority of the 4/13/15 dinner service NA-E and NA-F were not present in the dining room at the same time; this left one NA to assist four residents at two different tables. The NA that was left in the dining room alone moved from resident to resident and table to table, gave a few bites to all residents within minutes of each other. NAs were observed on several occasions to stand next to the resident when assisting them with eating. NAs did not wash/sanitize hands between residents after touching tables, wheelchairs, and wiping faces off.

During an interview on 4/13/15, at 5:11 p.m. NA-E referred to the west dining room as the " feeder dining room. " NA-E explained residents that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 241	Continued From page 7 required assistance with eating were assigned to that dining room on admission to the facility. During an interview on 4/16/15 at 10:04 a.m. registered nurse (RN)-F stated the dining room was referred to as the " feeder dining room " , stated residents could eat in the main dining room on the first floor, stated people that are not able to communicate preference are assigned to the " feeder dining room " on admission. RN-F was not aware if the meal was supposed to be removed from the serving tray or not. RN-F explained NAs supposed to wash/sanitize hands between residents and touching surfaces that may be contaminated. RN-F stated NAs had received education pertaining to hand washing and received education routinely. During an interview on 4/16/15, at 10:21 a.m. certified dietary manager (CDM) verified the west dining room on the 3rd floor was referred to as the " feeder dining room." CDM stated, " We put the " feeders " in that dining room on admission." CDM stated, " The meals go up on trays, they should be disassembling the trays and put in front of the resident." CDM stated, " We don ' t put placemats down [in reference to 3rd floor west dining room]." Facility policy Resident with Swallowing Difficulties date last revised 4/30/14 read, " Residents who eat in the 1st floor dining room must eat independently and are not at risk for aspiration." Facility policy East Dining Room Hostess/Nurse Aide Responsibilities last reviewed 4/29/15 instructed staff to " provide residents with prompt, dignified meal service, wash hands,	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 241	Continued From page 8 prevent spread of infection ...., serve all residents at a table before serving the next table ...., if a resident requires assist with eating, sit down beside him/her while assisting, arrange tray ..., never leave dining room unattended ... "	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure each resident's preference for waking up in the morning was respected for 2 of 3 residents (R62, R21) reviewed for choices. Findings include: R62's quarterly Minimum Data Set (MDS) dated 3/4/15, identified but not limited to diagnoses of heart failure, depression and diabetes mellitus and required extensive assist of one staff for transfers, dressing, personal hygiene and toileting. R62's brief interview for mental status (BIMS) score of nine indicated moderate cognitive impairment. R62 was interviewed on 4/14/15 at 8:36 a.m. in his room. When asked, "Do you choose when to	F 242	Resident R 62 was interviewed by surveyor and indicated that he liked to sleep in to 0800, at the time of interview it was 0700. Social services re-interviewed resident on 4/17/15. R 62 indicated that he liked to get up between 0700 and 0715 to allow him to visit with his table mates at the breakfast table. When R 62 was asked by social services why he told the surveyor 0800 compared to his 0700 he stated Sometimes I just like to complain, social services asked if he would like any change and R 62 said I would like to just keep things the way they are. R 21 was interviewed on 4/17/15 and requested no changes at this time. Stating "I never know when I want to get up".	5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 242	Continued From page 9 get up in the morning?" R62 responded, "No, they [staff] come and get me up when they are ready to get me up. I would like to sleep in till 8:00 a.m." R62's nursing admission progress note dated 1/13/11 read, "...likes to arise at 8AM ..." R62's nursing assistant undated care guide indicated his preference to, "arise [at] 8AM." However, the staff was getting R62 up earlier than 6:56 a.m. R62 was observed on 4/15/15 at 6:56 a.m. to be dressed for the day sitting in his wheelchair. On 04/15/2015 at 7:14 a.m. nursing assistant (NR)-D stated she got R62 up between 6:30 a.m. and 6:40 a.m. NR-D stated he gets up anywhere between 6:30 a.m. and 7:30 a.m. NR-D stated when residents are admitted they are asked up what time they would like to get up in the morning. NR-D stated R62 had not made a preference as for a time he would like to get up in the morning. NR-D was unaware of R62 ' s preferred time to get up at 8:00 a.m. even though this preference and time was indicated on nursing assistant care guide. On 4/16/2015 at 10:23 a.m. social services (SS)-A stated nursing completed preferences upon admission for residents, including when a resident would like to get up in the morning. SS-A stated staff should get R62 up at 8:00 a.m. in the morning as he preferred. SS-A verified R62 being up and dressed already for the day at 6:56 a.m. would not being following his preference to get up at 8:00 a.m. R21's re-admission 5 day PPS (prospective	F 242	Residents were reminded of resident rights at resident council on April 17th and their ability to express their preferences. We talked specifically about wake up times and HS times. Social services will weekly review preferences on morning routine for R21. R 62 and R 21 will continue to be interviewed weekly by social services until resident states that their routine is acceptable. Resident rights are reviewed by social services at resident council and are asked about any concerns to assure that preferences continue to be acceptable. Residents will be continued to be asked if their are any concerns at quarterly care conferences to assure all residents are reviewed. Director of Nursing has provided reeducation material to all staff, effective date of correction 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 242	Continued From page 10 payment system) MDS, dated 1/18/15, identified R21 had moderate cognitive impairment. During interview on 4/13/15, at 6:42 p.m. R21 stated she did not receive a choice in when she gets up in the morning, "You have to wait for staff." R21 stated she was unsure if she had ever been asked about, or told staff her wishes, "Because I know I have to wait." Further, R21 added, "We don't always just get what we want" regarding their morning routine preferences and choices. During observation of morning cares on 4/15/15, at 6:48 a.m. R21 was laying in her bed with her door open. R21 hollered out into the hallway, "Must be time to get up pretty damn soon" as the surveyor walked by her room. R21 stated she was waiting to get up and ready for the day, and turned her call light on at 6:50 a.m. adding, "They [staff] will probably say you have to wait you turn." Nursing assistant (NA)-B answered R21's call light at 7:00 a.m. (10 minutes later) and helped her begin to get up for the day. When interviewed on 4/15/15, at 7:09 a.m. NA-B stated he was aware R12 had a preference to be up early so she is ready for breakfast, however there are multiple residents to help in the facility. Further, NA-B added it was important to honor resident choices and preferences. During interview on 4/15/15, at 12:22 p.m. registered nurse (RN)-E stated resident preferences and choices were obtained on admission, but R21 did not appear to have this completed upon review of her record. Further, R21's preference for getting up early should have been honored.	F 242		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 242	Continued From page 11 An undated facility Residents' Bill of Rights identified, "You [resident] have the right to choose activities, schedules and health care...and make choices about aspects of your life in the facility that is significant to you."	F 242		
F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure a quiet and comfortable environment for 1 of 1 residents (R12) whom had complained about hallway noise during the course of the survey. Findings include: R12's quarterly Minimum Data Set (MDS), dated 1/28/15, identified R12 was cognitively intact, did not wear hearing aides, and had "adequate" hearing with "no difficulty in normal conversation, social interaction, listening to TV (television)." During interview on 4/14/15, at 8:59 a.m. R12 stated she was bothered by loud hallway noise and staff often chatting outside her door. When interviewed on 4/16/15, at 1:04 p.m. nursing assistant (NA)-C stated R12 had complained about the loud hallway noise before, adding the "girls [staff] were gabbing and	F 258	R 12 had complained of loud hallway noise bothering her, and staff often chatting outside her door. Resident currently resides near main elevator and nurses station. An update was placed in the communication book regarding staff to be mindful of noise level immediately after hearing of concern by evening nurse supervisor. Resident interviewed by social services on 4/17/15 and did not remember having a concern of noise. Again on 5/6/15 resident was interviewed by social services in regards to the hallway being noisy. R12 stated does occasionally get noisy, social services offered R12 a room change that would be further away from the nurses station, in which she declined a move of any kind. Social services educated R12 to inform staff if she feels the noise level is disturbing to her. Social Services will responsible for performing random audits	5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 258	Continued From page 12 laughing." Further, R12 had stated before she did not like it, and that any concerns about the loud hallway noise should have been reported to the nurses or administration. During interview on 4/16/15, at 1:07 p.m. licensed practical nurse (LPN)-G stated she was unaware of any concerns for R12 concerning loud hallway noise, but that NA staff should be reporting the concerns promptly so it can be addressed in the Communication Book (used to relay messages and updates about resident care to staff). Registered Nurse (RN)-A reviewed the Communication Book on 4/16/15, at 1:12 p.m. and was unable to locate any communication regarding the concerns of loud hallway noise for R12, stating there was "nothing about noise." During interview on 4/16/15, at 2:43 p.m. RN-F stated she was unaware of any concerns involving hallway noise for R12, but if R12 had a concern, she could complete a grievance form and bring it to social services. Further, the facility did not have a formal policy on noise levels and/or reduction.	F 258	on resident floors. Audits will be preformed weekly until accepted by QA committee. Staff was educated per our facility grievance policy (SS065) to fill out the grievance policy form and turn into social services for timely follow up. Policy and procedure for grievance updated stating that Grievances will be reviewed at morning stand-up meeting with IDT and follow up and education provided with involved staff. Director of Nursing provided reeducation material to all staff, effective date of correction 5/14/15.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an	F 280		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 280	Continued From page 13 interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to revise the care plan for 1 of 3 residents (R41) who had a decline in bladder continence over three month period of time. Findings include: R41 was admitted to the facility on 11/20/2014 according to the facility admission records with diagnoses that included but were not limited congestive heart failure, end stage lung disease, malaise, fatigue, and spinal cord myelodysplasia. R41's admission Minimum Data Set (MDS) dated 11/26/14 indicated no cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 15 and R41 required extensive assistance from one staff member for toileting. The MDS indicated R41 was occasionally incontinent of urine and received a diuretic medication. R41's medication administration record (MAR) included Lasix (diuretic medication) 40 milligrams (mg) by mouth twice per day. R41's care plan initiated on 12/2/2014 indicated R41 was at risk for alterations in skin integrity related to decreased independence in mobility and exposure to moisture from urinary	F 280	R 41 showed a decline in continence and care plan was not updated. R 41 has a history of choosing to urinate in her pad and then call for assistance rather than using the toilet. On 4/16/17 care plan was immediately updated by case manager. Previous case manager is no longer in the facility; new case manager was educated on 4/16/15 in regards to updating care plans in to assure accuracy for all aspects of care. All resident with care conferences have had care plans reviewed since 4/16/15. We will continue to monitor all care plans. All residents will continue to be monitored quarterly and as needed in regards to bowel and bladder function and assessment. Assistant director of nursing will audit care plans quarterly and as needed to insure accuracy of care plan residents function. Facility is installing a new electronic medical records system where nurses can chart and change the care plan; changes will be immediately available for all staff. Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 280	Continued From page 14 incontinence. The care plan identified history of incontinence and decreased awareness to void and read, "Resident is incontinent of urine occasionally ...has uterine prolapse and is at risk for urinary tract infection." The care plan failed to identify the amount of assistance R41 required for toileting. R41's significant change MDS dated 12/31/14 indicated R41 required extensive assist of one staff member for toileting, did not have a trial toileting program, was frequently incontinent of urine, and used a diuretic medication. However, the facility did not update R41's care plan to reflect the increase in urinary incontinence that had been coded on the significant change MDS. A communication that was written on the facility's Physician Orders form read, "Resident continues to refuse to get up out of bed for meals and visits with family. States she gets short of breath when she gets up. Resident will also void in her pad then put call light on to be changed immediately." The physician responded by ordering a trial of Klonopin for a week to "calm her down." R41's quarterly MDS dated 3/25/15 indicated R41 required extensive assist of one staff member for toileting, was always incontinent of urine, did not have a trial toileting program, and used a diuretic medication. Again the facility did not update the care plan to reflect the increase in urinary incontinence that had been coded on the quarterly MDS and the care plan did not reflect R41's pattern of intentional urinary incontinence to avoid becoming short of breath during toileting. During an interview on 4/16/2015, at 2:36 p.m. registered nurse (RN)-E verified care plan had not been updated for R41 after decline in incontinence status.	F 280	and infection control provided reeducation material for staff, effective date of correction 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 280	Continued From page 15 A facility policy pertaining to the care plan was asked for and not provided.	F 280		
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 observation, interview and document review, the facility failed to ensure the care plan was followed for 1 of 1 resident (R97), who was dependent of staff to place hearing aids for use. Findings Include: R97's quarterly Minimum Data Set (MDS) dated 3/4/15 indicated R97's ability to hear was adequate with the use of a hearing aid. R97's care plan, dated 03/15/13, read, "...Resident is able to communicate needs ...hearing is adequate with the use of bilat [bilateral] aides." In addition it directed staff to place hearing aids daily in the morning and the nurse was to check to ensure they were functioning properly and batteries were charged to make sure hearing aids were working. On 4/13/15 at 7:12 p.m. during an interview with R97 and her friend (FR)-A present, R97 was observed to not have her bilateral hearing aids in place. FR-A stated R97's bilateral hearing aids are often not in when she comes to visit her.	F 282	R 97 was found to not have hearing aids in place upon survey. R 97 prefers to keep her own hearing aids in her room and staff is to place them with morning cares with nurse to check to make sure they are placed and functioning properly. Signs have been placed in resident□s private room per resident and family's request, education in floor communication book, and placement on MAR to be checked and signed off, this education was done by Director of Nursing on 4/17/15. Assistant Director of nursing preformed immediate interviews on R 97's floor to assure all residents with hearing devices were in place and found no concerns from other residents. Audits will be performed on residents with hearing devices to ensure they are available and placed, this will be done bi weekly until practice accepted by QA committee. Going forward the hearing aid placement will be a designated task within our Point Click Care, EMR system. This will allow for an alert to make sure the hearing aids	5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 282	Continued From page 16 FR-A said she visits frequently during the week. On 4/16/15 at 9:30 a.m. R97 was observed to be sitting in her recliner in her room reading the newspaper and again her hearing aids had not been placed. On 4/16/15 at 9:32 a.m. licensed practical nurse (LPN)-H stated the nursing assistant who assisted R97 with morning cares was responsible for placing R97's hearing aids for the day. On 4/16/2015 9:38 a.m. during an observation LPN-H verified R97 did not have her hearing aids located in her ears and then LPN-H asked R97 if she would like to have her hearing aids placed in her ears and R97 stated, "Yes." LPN-H proceeded to placed R97's hearing aids in each ear and R97 thanked her. On 4/16/2015 at 10:03 a.m. social services (SS)-D stated her expectation was when staff was getting residents ready for the day their hearing aids should be placed. A care plan policy was requested and was not provided.	F 282	are placed. New case manager was educated on 4/17/15 in regards to updating care plans to assure accuracy for all aspects of care. Director of Nursing provided reeducation material for all staff, effective date of correction 5/14/15.	
F 313 SS=D	483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the	F 313		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 313	Continued From page 17 provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assure 1 of 1 resident (R97), who was dependent of staff to place hearing aids, was provided daily assistance to assure hearing devices were in place. Findings Include: R97's quarterly Minimum Data Set (MDS) dated 3/4/15 indicated R97's ability to hear was adequate with the use of a hearing aid. R97's care plan, dated 03/15/13, read, "...Resident is able to communicate needs ...hearing is adequate with the use of bilat [bilateral] aides [sic]." In addition it directed staff to place hearing aids daily in the morning and the nurse was to check to ensure they were functioning properly and batteries were working. On 4/13/15 at 7:12 p.m. during an interview with R97 and her friend (FR)-A present, R97 was observed to not have her bilateral hearing aids in place. FR-A stated R97's bilateral hearing aids are often not in when she comes to visit her. FR-A said she visits R97 frequently during the week. FR-A stated she had shared this concern with the facility staff on multiple occasions. FR-A proceeded to assist R97 with placing her hearing aids and told surveyor R97 would be able to hear the questions better now that she had her hearing aids in place. On 4/16/15 at 9:30 a.m. R97 was observed to be	F 313	R 97 was found to not have hearing aids in place upon survey. R 97 prefers to keep her own hearing aids in her room and staff is to place them with morning cares with nurse to check to make sure they are placed and functioning properly. Signs have been placed in resident□s private room per resident and family's request, education in floor communication book, and placement on MAR to be checked and signed off, this education was done by Director of Nursing on 4/17/15. Assistant Director of nursing preformed immediate interviews on R 97's floor to assure all residents with hearing devices were in place and found no concerns from other residents. Audits will be performed on residents with hearing devices to ensure they are available and placed, this will be done bi weekly until practice accepted by QA committee. Going forward the hearing aid placement will be a designated task within our Point Click Care, EMR system. This will allow for an alert to make sure the hearing aids are placed. New case manager was educated on 4/17/15 in regards to updating care plans to assure accuracy for all aspects of care. Director of Nursing provided reeducation material for all staff, effective date of correction 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 313	Continued From page 18 sitting in her recliner in her room reading the newspaper and again her hearing aides had not been placed. On 4/16/15 at 9:32 a.m. licensed practical nurse (LPN)-H stated the nursing assistant who assisted R97 with morning cares was responsible for placing R97's hearing aids for the day. LPN-H stated she was unaware R97's hearing aids not being placed on a daily basis was a concern for R97 and FR-A. On 4/16/2015 9:38 a.m. during an observation LPN-H verified R97 did not have her hearing aids in her ears and asked R97 if she would like to have her hearing aids placed in her ears and R97 stated, "Yes" LPN-H then placed R97's hearing aids and R97 thanked her. On 4/16/2015 at 10:03 a.m. social services (SS)-D stated FR-A had voiced a concern to her regarding R97's hearing aids not being placed. SS-D stated she communicated this concern to the nursing department at a morning stand up meeting for follow-up to ensure R97's hearing aids were being placed daily. SS-D stated her expectation was when staff was getting residents ready for the day their hearing aids should be placed. A policy was requested for hearing impaired residents and was not provided.	F 313		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores	F 314		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 314	Continued From page 19 does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate care and treatment including comprehensive assessment, prescribed treatment, and resident education, for 1 of 3 residents (R21) reviewed with a current pressure ulcer. This resulted in actual harm for R21. Findings include: According to documentation of a body audit assessment conducted 12/16/14, R21 had current pressure areas to his heels, and was at risk for development of pressure ulcers. A Braden Scale for Predicting Pressure Sore Risk had been conducted 12/30/14, and R21 had been identified as at high risk for pressure ulcer development with a score of 19 out of 24. The Care Area Assessment (CAA) regarding pressure ulcers dated 12/30/14, identified R21's risk for breakdown and current heel ulcers, but did not identify any other pressure ulcers. A Resident Incident Report dated 12/30/14 at 11:30 p.m., indicated staff had identified a reddened area on the resident's coccyx and purplish-black areas on the resident's buttocks bilaterally with observed skin slough. Subsequently, a physician's visit note dated 12/31/14, indicated the resident had been seen at the clinic for evaluation of the areas	F 314	R 21 was assessed on 12/16/14 and had current pressure areas to her heels and was at risk for development of pressure ulcers. On 12/30/14 resident scored a 19/24 making her high risk for pressure ulcer development. This assessment only showed the pressure areas on her heel, but did not identify any other pressure ulcers. On 12/30/14 resident was found to have a reddened area on resident□s coccyx and purplish/black areas on the resident□s buttocks bilaterally with observed skin slough. This was not identified on the 12/30/14 assessment. Director of Nursing came in on 12/31/15 at 0451 in the morning and observed area. Director of Nursing educated resident and staff in regards to wound condition and importance of relieving pressure while up in chair and in bed. A new cushion was applied to her wheelchair and air mattress to bed as interventions to help immediately remove pressure. Resident□s family initially refused physician visit, Director of Nursing scheduled appointment with family□s approval on 12/31/14. Physician indicated Patient has a poor medical condition. She has had radiation for her tumor and one	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 314	Continued From page 20 on her buttocks. The physician's documented plan from the visit note included: "PLAN 1. Stage 1 pressure ulcer of the buttocks...I did discuss with her in detail that there is not an open wound...I did discuss with her that the mainstay of treatment will be attempting to relieve the pressure on her buttocks. She did seem very reluctant to have any type of movement at all. She did become concerned once I discussed that these particular issues can get progressively worse if she does not follow wound care instructions..." R21 required hospitalization on 1/6/15, after she was noted to have a stage IV pressure ulcer on the coccyx. The hospital discharge summary indicated she had been readmitted to the facility on 1/14/15, with the use of a wound vacuum (VAC) system to treat the stage IV pressure ulcer. Although R21 had developed the stage IV pressure ulcer and had to be hospitalized, the facility had not completed a comprehensive reassessment of the resident's tissue after R21's return to the facility in order to determine what interventions to implement to promote healing of the pressure ulcers, and to help prevent further pressure ulcers from developing. An admission Minimum Data Set (MDS) dated 12/19/14, identified R21 as cognitively intact, required extensive assistance with transfers and bed mobility, had one current stage II pressure ulcer (the outer layer of skin and part of the underlying layer of skin is damaged or lost), and as remaining at risk for pressure ulcer development. Additional information documented on the CAA for pressure ulcers dated 12/30/14, indicated R21 had an "existing ulcer" on her left heel, required a special mattress, regular turning and repositioning, and needed staff assistance to	F 314	has to assume that the skin in this area is compromised. Following her surgery, the patient was in the nursing home and developed an ulceration on her coccyx which has gotten considerably worse, it is undermined, has significant drainage and surrounding cellulitis and that started approximately 12/31/14. Resident had completed personal home visits along with therapy home visit in hope to discharge around mid April 2015. Received fax confirmation to discharge home with home care for dressing changes. Payer source benefits would not pay for silversorb dressing in homecare setting. Primary physician did not want to discontinue current treatment and canceled order to discharge home , due to current treatment being effective with healing wound. Assistant Director of Nursing educated nurse who did dressing change during state observation on appropriate measurement and dressing. R 21's care plan and environment reviewed for appropriate pressure relieving interventions, Braden was completed. R 21's dressing was changed and reapplied according to physician orders. All residents are assessed for skin breakdown daily during routine cares. In addition, a full body audit is performed and completed during each resident□s bath. Infection control nurse immediately reviewed all residents with pressure areas to make sure policy and procedure were being preformed accurately. All staff will be educated on facility policy and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 314	Continued From page 21 move. In addition, the CAA documentation included: "Res [resident] is at risk for pressure areas r/t [related to] overall health issues, poor tissue perfusion, hx [history] of CA [cancer] / radiation." The CAA identified no need for referrals but directed staff to "proceed to care plan." The Resident Incident Report dated 12/30/14, further included: "Res. [resident] has poor tissue perfusion, often refuses to lay [should be lie] down during the day, prefers to sit up in w/c [wheelchair]. Often refuses to turn/repo [reposition] when prompted. Educated res. on importance of relieving pressure to bottom, educated staff to document refusals consistently." R21's Nurse's Notes from 12/31/14 at 4:51 a.m. identified; "Resident interviewed regarding buttocks wound. Resident states that she does sit too much and admits to not laying down when she should. Observed area [with] nurse and aide. Purple area approximately 8 cm X 4 cm [with] a slightly open draining area at the top... Wound flow sheet was filled out and education to resident and staff about its condition and importance of relieving pressure while up in chair and in bed. Will apply new cushion to chair and air mattress to bed as interventions to help relieve pressure areas." When nursing assistant (NA)-D was interviewed about the pressure ulcer on 4/15/15 at 10:03 a.m. she stated, "It just showed up, shortly after she got here." NA-D also stated the staff help R21 reposition every two hours or as she requests. However, during a subsequent interview on 4/15/15 at 10:54 a.m., NA-D stated R21 had been resistive to repositioning since she had been	F 314	procedure regarding the need for body audits to be completed on residents within 24 hours of admission and within 24 hours of a resident returning from the hospital. The Director of Nursing completed training of a new nurse case manager on 4/17/15. Skin risk assessments will be completed on admissions, readmissions, quarterly and upon significant changes in condition. The facility revised its policy and procedure for wound care to address repositioning timely, assessments of residents at risk for pressure ulcers, the proper way to measure a wound, and the need to follow physician□s orders for wound care. The revised policy and procedure for wound care also included education of residents regarding skin integrity issues and the risk for skin breakdown. This policy now also includes steps to take if resident refuses to reposition timely. Any resident with pressure wounds will be audited by infection control nurse for appropriate prevention, dressing and measurement procedure bi-weekly until wound is resolved. The facility will monitor its performance and the effectiveness of the above measures through regular audits and assessments related to wound care and skin integrity. The Director of Nursing and infection control nurse will be responsible for implementing and monitoring the facility□s corrective measures. The facility□s QA committee will also monitor the effectiveness of the measures implemented. Director of Nursing and infection control	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 314	Continued From page 22 admitted to the facility. Record review indicated the first time staff had addressed any reluctance with repositioning, and risks/consequences associated, had been on 12/31/14 after the coccyx ulcer had been identified. Additional documentation on the physician's progress report from 12/31/14, included: "...The patient will also be encouraged to stay out of her wheelchair and at times lying in her bed with turning every 2 hours to keep pressure off this affected area. We will also see if we can get her a cushion that will help also prevent direct pressure on this area..." The progress note also indicated to "return to clinic in approximately 3 weeks for repeat assessment unless any acute issues develop before hand." A History and Physical (H&P) dated 1/6/15, indicated R21 had been admitted to the hospital on 1/6/15 for intravenous antibiotics and wound care. The note included: "She was seen here in clinic on 12/31, with a reddened area on her coccyx. Apparently no ulceration, her breakage of skin surface was noted at that time...she has developed an ulceration in the coccyx area...The patient has developed since 12/31, a deep coccyx ulceration with apparent probable undermining and a purulent malodorous discharge. There is surrounding erythema. There has been some discomfort associated with this. Apparently the patient has been very difficult to regarding-position." A consultation note from a consult conducted by a surgeon on 1/8/15, included: "...Patient has a poor medical condition. She has had radiation for her tumor and one has to assume that the skin in this area is	F 314	provided reeducation material for staff, effective date of correction 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 314	Continued From page 23	F 314		

compromised. Following her surgery, the patient was in the nursing home and developed an ulceration on her coccyx which has gotten considerably worse.

Following R21's readmission from the hospital, a 5 day PPS (prospective payment system) MDS, dated 1/18/15, identified R21 now had moderate cognitive impairment, continued to require extensive assistance with transfers and bed mobility, and now had one stage II pressure ulcer along with one stage IV pressure ulcer.

R21's care plan, dated 1/28/15, identified R21 had fragile skin, a "heel ulcer present on admission", and "often refuses to lay [should be lie] down, get off bottom thru the day when staff prompt her to do so." A goal was identified of, "Resident will have area on heel + [and] coccyx healed by next review." Further, the care plan identified interventions which included, "Float heels when in bed", "Pressure reducing mattress & [and] cushion in w/c [wheelchair]", and "follow treatments for L/heel [left heel] + coccyx as per current orders - see tx [treatment] sheets."

R21's medical record was reviewed, there was no indication a comprehensive pressure ulcer reassessment was completed despite R21 being hospitalized for the development of a stage IV pressure ulcer. The facility only completed a Braden Scale, which only identifies a numerical rating of low or high risk. There was no indication the facility changed their pressure ulcer interventions from the admission Braden Scale of 12/30/14, even though R21 had developed a stage IV ulcer on her coccyx.

On 4/15/15, at 11:08 a.m. registered nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 314	Continued From page 24	F 314		

(RN)-E and RN-F were interviewed regarding R21's pressure ulcer. They confirmed R21 had routinely refused repositioning since her admission however, the facility had not completed any education regarding risks of not being repositioned, until the breakdown on her coccyx. RN-F also stated R21 should have been comprehensively reassessed for pressure ulcer risks when she'd returned from the hospital.

R21's Surgery progress note, dated 1/20/15, identified, "The patient [R21] underwent a complex debridement of a coccyges decubitus ulcer [pressure ulcer] on January 12, 2015. Following this procedure, a VAC wound care device [uses medical foam and a small vacuum to create negative pressure on a wound or pressure ulcer which facilitates healing], was placed." A further Surgery progress note, dated 2/5/15, identified R21 was seen for "a stage 4 decubitus ulcer located in her coccygeal area", and, "The patient [R21] was last evaluated in Surgery Clinic on January 27, 2015 when she was noted to have an inadequately placed VAC unit, along with a small sponge within the large coccygeal decubitus ulcer." Further, the note identified, "additional instructions were given to the wound specialist at patient's [R21] nursing home." The dressing was not removed at the appointment, so the ulcer was not evaluated for undermining. A subsequent Surgery progress note, dated 3/23/15, identified R21's ulcer "is at the deepest along the left lateral and left inferior aspect of the wound", and, "No fistulas, tunneling or undermining noted." Further, the note identified, "I [nurse practitioner (NP)-A] did contact nursing home staff and talked with [LPN-B] in regards to the wound dressing...they had been advised approximate 2 weeks ago by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 314	Continued From page 25 [PT], to obtain a foam roping to place in the wound as the foam they have was not completely filling the open wound." A Medical Information Exchange Form, dated 3/30/15, identified R21 had been seen in the clinic on 3/30/15 for a "coccyx ulcer", and included a treatment which identified, "Continue [with] wound vac. Make sure to pack deep into left deep aspect of wound." R21's condition was identified as "stable" by the NP-A. A review of R21's Wound Flowsheets identified the following information: On 4/2/15, the pressure ulcer measured 4 cm X 3 cm X 1 cm in size, was "healing", and listed a treatment of, "Continue current treatment." On 4/3/15, the pressure ulcer measured 4 cm X 3 cm X 0.8 cm in size, was "healing", and continued to identify, "Continue current treatment." On 4/8/15, the pressure ulcer measured 3 cm X 2 cm X 1.5 cm in size, continued as "healing", and for staff to "Continue current treatment." On 4/10/15, the pressure ulcer measured 4 cm X 2 cm X 1.5 cm in size, remained identified as "healing", and for staff to, "Continue current treatment." No undermining was identified on the flow sheets for R21's pressure ulcer. During observation of pressure ulcer care, on 4/15/15 at 1:29 p.m. RN-D removed a non-coil type wound VAC dressing and exposed a stage IV pressure ulcer on R21's coccyx. The wound was symmetrical in shape, with granulation tissue (beefy red tissue indicative of healing) and approximately 50 percent (%) slough tissue (necrotic tissue). The pressure ulcer had undermining on all sides of the wound. RN-D measured the wound using a paper tape	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 314	Continued From page 26	F 314		

measure that had been included in the new wound VAC kit. RN-D measured the opening of the wound at 3 cm (length) X 2 cm (width) X 1.5 cm (depth). However, RN-D did not measure the depth of the wound at its deepest point or use any measuring tool to identify the depth and degree of the pressure ulcer's undermining. RN-D opened a new VAC Granufoam Silver dressing kit and cut the foam down to the size of the ulcer opening, and applied it into the opening of the pressure ulcer. RN-D did not use a foam coil dressing, or pack the foam into the undermining of the ulcer. RN-D cut a new clear film, draped the ulcer using the film, and applied a new central disc piece that attaches the dressing to the vacuum device.

When interviewed immediately after the observation of pressure ulcer care, on 4/15/15 at 1:43 p.m. RN-D stated she last observed R21's pressure ulcer on 4/6/15 and it did not have any undermining at that time. RN-D cut the new piece of foam to better fit the wound today, but verified she did not pack the foam into the undermining of the wound as the physician had instructed in the progress notes. On asking RN-D if she had any education on the use and application of the wound VAC system she replied she had no formal education on the wound VAC system, only having knowledge of the device and dressings from, "What we learned in school." When R21 had the wound VAC placed, a physical therapist (PT)-A had come and performed education on how to complete R21's dressing change; however RN-D was unable to attend the demonstration. Further, RN-D stated she completed the dressing change as she had been shown by other nurses.

During interview on 4/15/15, at 2:50 p.m. PT-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 314	Continued From page 27	F 314		

stated she had last seen the wound about a month prior when R21 had come to the clinic for an appointment with NP-A. The NP-A had written specific instructions for the nursing home staff to follow regarding the pressure ulcer treatment, including packing the undermining and tunnels of the wound using the VAC foam. PT-A stated R21 had come into the clinic (1/27/15) from the nursing home before with the dressing not completed correctly (in regards to the VAC wound dressing), so she (PT-A) had went to the nursing home and completed a demonstration for two nurses on how to complete the pressure ulcer dressing change using the VAC foam and device. Further, the staff were left with instructions to call her or KCI (the manufacturer of the VAC system) if they had questions.

An interview was attempted with the NP-A on 4/15/15, at 2:59 p.m.; however she was, "out of the office for a period of time."

During interview on 4/15/15, at 3:01 p.m. R21's surgeon's nurse, LPN-O was interviewed regarding R21's stage IV pressure ulcer. R21 was last seen on 3/30/15 by NP-A and the nursing home staff was advised to pack the ulcer and place the foam dressing "into the deepest aspect of the left inferior portion of the decubitus wound."

When interviewed on 4/16/15, at 9:53 a.m. RN-E stated she had never changed R21's VAC dressing herself, but last observed R21's pressure ulcer in late March 2015 and at that time had not gotten a clear look at it. RN-E then added that R21 ' s pressure ulcer undermining should be packed with the VAC foam, "To heal from underneath, to the bottom up." RN-E was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 314	Continued From page 28 unaware what formal education had been completed for the staff regarding R21's dressing changes, but that staff should be measuring the wound from the deepest part. Further, RN-E stated the measurements collected of R21's pressure ulcer at the facility which were documented on the Wound Flowsheets were likely not accurate especially if the dressing changes were not completed as directed by the physician, it could have worsened R21's pressure ulcer, "Possibly, yea." The director of nursing (DON) was off campus on 4/16/15, and unavailable for interview regarding R21's pressure ulcer care and treatments. A facility Wound Care policy, dated 4/30/14, identified a purpose of, "To prevent or minimize transmission of microorganisms during wound care procedures." The policy lacked any guidance for staff regarding when to explain the risks of failing to reposition timely, conduct assessment of a resident's risk for pressure ulcers, or for following physician guidance for wound care.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 315	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to comprehensively reassess the need for an individualized toileting program following a decline in urinary continence for 1 of 3 residents (R41) reviewed for urinary incontinence. Findings include: R41 was admitted to the facility on 11/20/2014 according to the facility admission records with diagnoses that included but were not limited congestive heart failure, end stage lung disease, malaise and fatigue, and spinal cord myelodysplasia. R41's admission Minimum Data Set (MDS) dated 11/26/14 indicated no cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 15 and R41 required extensive assistance from one staff member for toileting. The MDS indicated R41 did not have a trial toileting program and was occasionally incontinent of urine and received daily diuretic medication. R41's medication administration record (MAR) included Lasix (diuretic medication) 40 milligrams (mg) by mouth twice per day. R41's admission Bladder Evaluation indicated R41 was prescribed a diuretic, had mixed incontinence, had a history of incontinence, voiding pattern was upon rising and after meals, had 2-6 incontinence episodes per week, had a stage 1 pressure ulcer, and perception of need to void was diminished.	F 315	R 41 showed a decline in continence and care plan was not updated. R 41 has a history of choosing to urinate in her pad and then call for assistance rather than using the toilet. On 4/16/17 care plan was immediately updated by case manager. Previous case manager is no longer in the facility; new case manager was educated on 4/16/15 in regards to updating care plans in to assure accuracy for all aspects of care. Infection control nurse reassessed R 41 on 4/16/15 and attempted to offer R 41 a toileting schedule in which she refused and was education in regards to the risks involved with refusal. All residents will continue to be monitored quarterly and as needed in regards to bowel and bladder function and assessment, those residents with care conferences since 4/16/15 have had bowel and bladder assessed and all needs addressed. Assistant director of nursing will audit bowel and bladder assessments quarterly and as needed to insure accuracy of needs for urinary incontinence is addressed on care plan. Facility is installing a new electronic medical records system where nurses can chart and change the care plan; changes will be immediately available for all staff. Director of Nursing and infection control provided reeducation material for staff, effective date of correction 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 315	Continued From page 30	F 315		

R41's admission Bowel and Bladder Needs Evaluation revealed a score of 14 which indicated "Probable candidate for scheduled toileting program."

R41's care plan initiated on 12/2/2014 indicated R41 was at risk for alterations in skin integrity related to decreased independence in mobility and exposure to moisture from urinary incontinence. The care plan identified history of incontinence and decreased awareness to void and read, "resident is incontinent of urine occasionally ...has uterine prolapse and is at risk for urinary tract infection." The care plan failed to identify the amount of assistance R41 required for toileting and an individualized toileting routine or program.

R41's significant change MDS dated 12/31/14 indicated R41 required extensive assist of one staff member for toileting, did not have a trial toileting program, was frequently incontinent of urine, and used a diuretic medication. This was a decline from R41's admission MDS in bladder incontinence. However, the facility did not revise the care plan to reflect the increase in urinary incontinence that had been coded on the significant change MDS also the facility did not comprehensively reassess the need for a toileting program in the presence of an increase in urinary incontinence since the MDS completed on 11/26/14.

A communication faxed to the physician in regards to bladder incontinence written on the facility's Physician Orders form dated 2/25/15 and author was a registered nurse stated R41 continues to refuse to get up out of bed for meals

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 315	Continued From page 31	F 315		

and visits with family. States she gets short of breath when she gets up. Resident will also void in her pad then put call light on to be changed immediately. The physician responded to communication by ordering a trial of Klonopin for a week trial for something to calm her down.

R41's quarterly MDS dated 3/25/15 indicated R41 required extensive assist of one staff member for toileting, was always incontinent of urine, and was not on a trial toileting program.

The corresponding Bowel and Bladder Quarterly Review dated 3/31/15 read, "Resident remains incont. [incontinent] of urine, but cont. [continent of Bowel. At risk for UTI [urinary tract infection] R/t [related to] Urinary incont. and diuretic use."

Again the quarterly assessment showed decline in bladder continence and again there was no revisions to the comprehensive care plan to address this decline.

During an interview on 4/16/2015, at 2:36 p.m. registered nurse (RN)-E verified care plan had not been revised to address decline in continence for R41.

Facility policy Bowel and Bladder Evaluation last revised on 4/29/14 read under POLICY: "Based on the resident's comprehensive assessment, the facility will ensure that each resident with bowel or bladder incontinence will receive appropriate treatment and services to restore as much normal bowel or bladder functioning as possible." Under PROCEDURE: it read,"1. Each resident will be assessed for 7 days for bowel and bladder voiding patters on admission, quarterly, and with significant change with evaluation for feasibility in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 315	Continued From page 32 retraining for bowel and/or bladder control." "4. The resident's plan of care will be developed to address the issue, goals and appropriate interventions."	F 315		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing staff checked placement of a gastrostomy tube prior to infusing medication and formula for 1 of 1 resident (R57) observed to have a tube feeding during the survey.	F 322	Resident R 57 was administered a tube feeding without proper tube placement verification prior to administration of formula. On 4/16/15 nurse was reeducated on facility policy and procedure by Director of Nursing. Facility Policy and Procedure indicates staff is to	5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 322	Continued From page 33 Findings include: R57's annual Minimum Data Set (MDS), dated 2/11/15, identified R57 was cognitively intact, and received "51 percent (%) or more" of her total calories through the feeding tube. During observation of medication administration on 4/16/15, at 7:50 a.m. registered nurse (RN)-A had set up R57's medications and brought several cups of crushed oral medication into her room. RN-A applied a pair of non-sterile gloves in R57's bathroom, while R57 removed a clear gastrostomy tube from her clothing, laying it on a towel she placed on her lap. RN-A brought over a metal pole (to hang the bad of formula from), which contained a stethoscope, kneeled down beside R57 and poured the prepared medications into a 60 cubic centimeters (CC) syringe which she was attached to R57's gastrostomy tube. RN-A did not check the placement of R57's gastrostomy tube with the stethoscope hanging on the metal poll prior to infusing the medications. At 8:24 a.m. RN-A removed a new clear feeding bag from the package, and hung it up on the metal pole, and allowed the tube feeding formula to begin to infuse to R57's gastrostomy tube via gravity. Again RN-A did not check placement of the feeding tube with the use of a stethoscope after infusing R57's medications, or before beginning the infusion of her formula. When interviewed on 4/16/15, at 8:38 a.m. in regards to the feeding tube, RN-A stated she had not received any formal education on tube feedings since being hired at the facility, only having "what I got in the hospital" for training back in 2009. RN-A identified that R57, at times, had	F 322	check tube placement by placing a stethoscope over stomach and instill a small amount of air into enteral feeding tube. Listen for air to enter the stomach. If position of tube is not verified as correct, hold feeding and or flush and notify physician. An internal education program through Educare will be assigned to all licensed nursing staff called Medication Administration II □ Feed Tubes. This will provided additional education to anyone taking care of resident R 57. Tube feeding audits will be performed bi weekly until accepted by QA committee. R 57 is currently the only resident in the facility with a feeding tube. Director of nursing provided educational material to all staff, effective date of correction is 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 322	Continued From page 34 been noted to mess with her tubing. Further, RN-A stated she should have checked the placement of R57's feeding tube prior to infusing medication or formula "to make sure its in her stomach." During interview on 4/16/15, at 9:48 a.m. in regards to R57 ' s feeding tube, RN- E stated she was unaware of any formal education offered by the facility that was completed with nurses for feeding tubes. Further, R57's feeding tube should have been checked for correct placement prior to infusing medication or formula. A facility Enteral Nutritional Feeding policy, dated 4/29/14, identified a procedure which included, "Verify tube placement...before administering formula...before administering medications..."	F 322		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently monitor	F 325	R 97 was found to not be monitored for significant weight loss and found to not	5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 325	Continued From page 35 weights and reassess for significant weight loss for 1 of 3 residents (R97) who had been reviewed for nutritional status. Findings Include: R97 was observed to eat her toast with two glasses of juice during breakfast on 04/15/2015 at 9:20 a.m. Resident said at this time she usually does not eat breakfast but said her toast tasted good. Again on 04/15/2015 at 12:27 p.m. R97 was observed to eat her lunch independently, ate 100% of her pork chop, 100% of her yogurt. 3/4 of yogurt. drank 4 ounces of Ensure clear, 10 ounces of milk, none of green beans, 3/4 of potatoes and gravy about 6 ounces of water. R97's quarterly Minimum Data Set (MDS) dated 3-4-15, identified diagnoses of anxiety disorder and depression. A brief interview for mental status (BIMS) score of 5 indicated severe cognitive impairment and needed assist of one staff member for setup help only for eating. Review of R97's weights was documented as follows: 12-11-14: 117 (first weight taken at the facility) 12-24-14: 107 1-29-15: 106 R97 had an 11 lbs. weight loss between 12-11-14 and 12-24-14; this was 8.62% weight loss. The initial nutritional therapy assessment dated 12-8-15 read, "... Admit weight 129 lbs., Current weight 129 lbs., Recent weight 116 lbs. at Woodland Assisted Living ...,Edema on Admit; 2	F 325	have accurate meal intakes recorded. R 97 will have her weights taken weekly and monitored until stable for 60 days. All residents will be audited by CDM for appropriate documentation of weights bi-weekly until approved by QA committee. New dining room intake sheet were created and provided to dining room on 5/4/15 by Director of Nursing. The facility is in the process of transitioning to an Electronic Medical Records system, which will allow for easier tracking of weights, and food/supplement intakes on the electronic MAR. Weekly weights, along with gains/losses will be more accurately tracked. The certified dietary manager and nursing administration will meet as part of the interdisciplinary team and discuss at standup meetings any changes of concern such as weight loss. Director of nursing and Certified Dietary Manager provided educational material for all staff; effective date of correction is 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 325	Continued From page 36 plus edema in right arm...Diet Order: Regular...Portion size: regular...Nutrition Interventions started: none indicated..." R97's registered dietician (RD) progress note dated 12-8-14 read, "Initial assessment...Is on a regular diet ...Notice of admit form indicated she was recently 116# [pounds] at Woodland A.L. [assisted living], came to Lakeview at 129# [pounds]. Note post op [operative] hip edema is common. IDWR [ideal weight range] 121-149 # [pounds]. Current BMI [body mass index] 20.2 ...note documentation of edema in her right arm, which staff writes is new for her. Will monitor intakes and weights to determine if nutrition approaches are indicated. Will aim to hold her weight > [greater than] 115 lbs. and encourage intake of 50% or better at her meals." R97's intakes were reviewed from December 2014 to April 2015. Documentation of meal intake was not consistent, and there was no documentation found for meal intakes for the month of March 2015. R97's medication administration records (MAR) were reviewed since admission. There was no documentation resident was to receive a nutritional supplement until 2-12-2015. At that time Kemps BID (twice a day) with meals was written on the top of the medication administration page. Nursing was not signing off when the supplement was given or documenting how much of the supplement was consumed by R97. The February 2015 MAR was reviewed and indicated on 2-17-15, R97 preferred Ensure clear and at this time the nurses started to document when the ensure clear was given, however did not document amount R97's consumed. R97's nutritional status care plan with a revised	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 325	Continued From page 37	F 325		

date 2-23-15 read, " At risk for nutritional status. DX [Diagnosis]; left hip FX [fracture], anxiety, depression. No chewing or swallowing difficulty. Able to feed self. IBWR [ideal body weight range]: 121-149# [pounds] Total protein and albumin levels are low. Res [resident] has lost wt. [weight]. Appetite is poor most meals; she says she is not hungry." Goal dated 2-23-15 read R97, " will drink 75% of supplement." Interventions included, " Diet: regular, Provide meals to 2nd floor dining room. Provide set up help as needed, offer snack between meals (added to care plan 2-23-15) Enc. intake at meals, esp [especially] of protein foods, 4 oz [ounces] Ensure clear TID [three times a day] (BID [twice a day] with meds at am/pm, [morning/evening] noon meal)." The supplement was added to the care plan on 2-13-15.

R97's registered dietician progress note dated 12-13-15 read, "...note her weight is down to 117# [pounds] on 12-11-14, back to her usual weight. BMI [body mass index] noted to be low at 18.3. Will recommend staff see if she would accept 4 oz [ounces] Kemps [supplement] 1-2 x [times] a day with med [medication] pass."

R97's certified dietary manager (CDM) progress note dated 1-12-15 read, " will start 4 oz [ounces] Kemps BID [twice a day] with meds [medication] pass."

R97's registered dietician progress note dated 2-23-15 read, "referred to dietary for poor intake. Was recently hospitalized d/t [due to] acute cholelithiasis (gall stones) ...small frequent meals recommended by the provider. Intake has been between 0-50%. Weight decreased to 107# [pounds] by late December 2014. Had stayed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 325	Continued From page 38	F 325		

pretty stable before her hospital stay in feb [February]. Was 108# [pounds] on 2-12-15...was started on kemps but did not like it. Ensure clear was ordered instead on 2-17-15...Talked with R97 today about her appetite. She tells me she is never hungry and gets full quickly. She continues to tell me she doesn't want to eat breakfast or a mid-morning snack..."

R97's medical record was reviewed and documentation revealed the physician was first notified of R97's weight loss on 2-23-15 by the RD when she requested an on order for ensure clear 4 ounces three times a day due to poor intake and weight loss. The facility was unable to provide any previous documentation of notification of R97's weight loss to the physician.

On 4/16/2015 at 12:49 p.m. the certified dietary manager (CDM) stated she was aware of R97's weight loss and stated R87 was not a breakfast eater and agreed to have snacks in her room in a basket to eat throughout the day. The CDM stated nursing was responsible to document and monitor meal intakes and stated the RD monitored R97's weight on a monthly basis. The CDM stated the protocol was when a nurse noticed a weight loss, they are to notify dietary and she would notify the RD. The CDM stated, " I know they didn't let me know about R97's weight loss, because I would have written it down on my sheet and I would have alerted the RD of the need to see the patient." The CDM stated residents should be weighed weekly on their bath day and this is not getting done. The CDM stated she had talked to the director of nursing (DON) to have him ensure residents are being weighed as this was a concern. The CDM stated, "There have been times when I have looked at a chart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 325	Continued From page 39	F 325		

and I don't see a weight for the whole month. It is a big concern." The CDM stated, "There are so many places to document a weight, I think the staff is just not weighing them." The CDM again stated, " Nurses should have informed dietary of R97's weight loss and I know for a fact they did not inform us of her." The CDM stated the RD completed the first nutritional assessment, and monitored residents' weights on a monthly basis. The CDM verified there was no RD documentation for the month of January in the medical record. The CDM stated she became aware of R97's weight loss in February after the RD did her assessment on 2-23-15.

On 4/16/15 at 2:03 p.m. registered nurse (RN)-F stated she found no additional weights or monitoring of the kemps supplement for R97. RN-F stated weights should be taken weekly with R97's bath and as the nurse was writing the weight in the chart, the nurse was to monitor the weights for weight gain, loss or stability. RN-F stated if the nurse noticed a weight loss they should increase frequency of weights being taken and notify dietary of the weight loss. RN-F verified this protocol was not followed for R97. RN-F verified R97 had a significant weight loss during the first month of her stay in the facility.

On 4/15/15 3:46 p.m. RN-F stated she was unable to find any documentation of notification to the physician regarding R97 weight loss until 2-23-15, when the RD requested an order for the clear ensure 4 ounces three times a day.

Review of the Weighing Residents undated policy read, "Purpose: To maintain control of weight gain or loss ...Procedure...2. All residents are weighed on admission, weekly and per doctor's order. 3.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 325	Continued From page 40 Periodic weight checks should be made on residents with physical disorders, such as anorexia, dehydration, obesity, edema, or whenever otherwise indicated. 4. Nursing assistants should record the weights on the vitals sheets. 6. Notify physician of any significant weight loss or gain above 5 pounds gained or lost. 7. Consult with dietician if resident loses or gains weight in excess of normal range."	F 325		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 329	Continued From page 41 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to identify target behaviors for the use an antipsychotic, mood and behavior for use of psychoactive medications to determine if they were affective. Also to attempt a gradual dose reduction/taper twice within the first year of starting the medication or a physician ' s justification as to why it was contraindicated. Also lack of monitoring antipsychotic medication for side effects was not done. This was noted for 1 of 5 residents (R83) reviewed for unnecessary medications. Findings include: R83 was admitted to the facility on 5/23/2014 according to the facility's admission record. R83's facility Diseases Index Report revealed R83 was admitted to the facility with diagnoses that included but were not limited to dementia with behavioral disturbance and depressive disorder. The diagnosis of Schizophrenia with acute exacerbation was added on 5/30/14 and the diagnosis of paranoia agitation was added on 6/27/14. R83's quarterly Minimum Data Set (MDS) dated 10/29/14 indicated severe cognitive impairment and displayed behavioral symptoms not directed at others one to three days during the assessment period. The MDS revealed a staff assessed mood monitoring (PHQ-9) score of 10 indicating moderate depressive symptoms. The MDS also indicated R83 required extensive of one staff member for activities of daily living with the exception of bed mobility where R83 required assist of two staff members. Signed physician orders dated 4/12/15 included Risperdal (antipsychotic medication) 0.5 mg by mouth once per day for diagnoses of	F 329	R 83 was found to not have proper target behavior for the use of an antipsychotic and mood stabilizing medication. Facility was not monitoring R 83□s diagnosis of paranoia on the behavior monitoring sheets. New Drug review was perfumed by nurse case manager and sent to primary physician for review. Previous nurse case manager is no longer with the facility, on 4/16/15 new nurse case manager corrected behavior monitoring sheets and care plan to accurately track diagnosis behaviors. Nurse case manager reviewed residents with antipsychotic and mood stabilizing medications to ensure no further issues. Education was done by assistant DON on 4/16/15 in regards to importance of tracking target behaviors with all antipsychotic and mood stabilizing medications. Currently all antipsychotic and mood stabilizing medications along with their target behaviors are addressed at each care conference and quarterly with consultant pharmacist reviews. As of correction date the pharmacists psychoactive drug review every six months the facility will also provide documentation for state requirements for physicians with the review on all residents. Nurse case manager will fill out quarterly drug review on all residents with antipsychotic and mood stabilizing medications. Consulting pharmacist's form with drug review will be reviewed by primary physician and audited for following policy and procedure by director of nursing this will be on going checking	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 329	Continued From page 42 paranoia/agitation. The original start date was 6/23/14 and was administered twice per day; order was changed to 0.5 mg once per day in November 2014. There was no indication that the resident was not assessed for potential extrapyramidal side effects after the initiation of Risperdal June 2014 nor was there side effects assessed after the dose reduction November 2014. There was no resident specific target behaviors identified to determine if the Risperdal was affective or not. Signed physician orders dated 4/12/15 included Depakote (mood stabilizing medication) 250 mg by mouth once per day. The original start date had been 7/30/14. There was no information in regards to attempting a gradual dose tapering of the Depakote since the medication was started on 7/30/14. There was no resident specific target behaviors identified to determine if the medication was affective or not. Signed physician orders dated 4/12/15 included Trazodone (antidepressant medication which is used for insomnia) 50 milligrams (mg) by mouth before bed and 50 mg by mouth as needed if not asleep in one hour. The start date of Trazodone was 6/17/14. The as needed order was added on 7/23/14. The pharmacist recommended reducing the Trazodone to 25 mg 7/24/14 due to possible side effects of resident falling. The Trazodone was not reduced at this time and there was no gradual dose taper done since ordered on 6/17/14 or a physician ' s justification as to why the gradual dose tapering was contraindicated at this time. Signed physician orders dated 4/12/15 included Zoloft 100 milligrams (mg) every day for depression. The original start date of Zoloft was pre-hospitalization. The physician had ordered	F 329	for medication irregularities. Director of Nursing and Assistant Director of Nursing provided reeducation material for all staff; effective date of correction is 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 329	Continued From page 43 Zoloft be reduced to 50 mg per day times one week in July 2014 then it returned to current dose of 100 mg per day. There was no gradual dose reduction attempted twice in the first year being on Zoloft nor was there a physician ' s justification as to why it was contraindicated to reduce the Zoloft. A pharmacist note dated 8/8/14 included "family has declined this med change" as a reason a gradual dose taper was not attempted. However, this is not an acceptable reason for not attempting a dose reduction. Also the Zoloft lacked specific resident mood and/or behaviors to monitor to determine if the Zoloft was affective. R83's care plan with a last review date of 11/13/2014 identified R83 had severe dementia, paranoid state and depression. It alerted staff R83's alertness fluctuated, had a lack of safety awareness and was impulsive. The care plan identified target behaviors as "crying and restlessness." The care plan gave the direction, "mood and behavior monitoring sheets to be filled in by NAR's [nursing assistant registered] every shift." The care plan lacked identification of individualized interventions for Zoloft and Trazodone. The care plan lacked any individualized target behaviors or interventions for the use of Risperdal and Depakote. The only behavior monitoring tracking form that was evident in the medical record was from March 2015 and had been used to monitor depression. The target behaviors indicated were crying/restlessness. The interventions that were listed were generic and not resident specific. The documentation reflected 1 episode of crying and restless for the month of March. During an interview on 4/15/15 registered nurse (RN)-E verified the facility had not developed target behaviors and interventions and monitoring	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 329	Continued From page 44 had not been performed. RN-E verified there were not individualized interventions for target behaviors of restlessness and crying for mood monitoring for depression. A facility policy Pharmaceutical Services read, "nurses shall monitor the administered medications dose response ...nurses shall monitor for beneficial therapeutic response, adverse drug response, common side effects, lack of therapeutic response, lack of resident response." and "Monthly the nursing staff shall chart a summary of observe dose-response of the administered medications." and "The consultant pharmacist shall monitor all aspects of medication utilization ..." and "The nursing staff shall obtain the primary medical diagnosis indicating the reason for psychoactive medication order. The goal of the psychoactive drug therapy should be specified in the resident's history or in the physician's progress notes. This information will be listed on the pharmaceutical care plan and on behavior monitoring sheets ...the nursing staff shall define and list targeted behavior symptoms, which shall be monitored and counted for the purpose of defining psychoactive dose response ...The attending physicians shall reevaluate all psychoactive orders at least every six months. This reevaluation shall document the psychoactive dose response, therapeutic outcomes and shall attempt to determine the lowest effective control dose of the drug ..."	F 329		
F 371 SS=E	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	F 371		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 371	Continued From page 45 (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility, failed to ensure safe refrigerated food storage, failed to ensure sanitary dish storage, and failed to develop and implement a policy and procedure for safe food handling of leftover foods. This had the potential to effect 63 out of 64 residents. Findings included: During kitchen tour on 4/13/15 at 3:10 p.m. guided by the certified dietary manager (CDM) observation revealed the following in the reach in cooler: 1 open bag of whipped topping approximately one half gone dated 3/4/15. The CDM verified the date on the bag of whipped topping and stated it should have been discarded. During the tour of the dry dish storage area guided by the CDM, observation of the cup and bowl dry storage rack revealed a stack of 4 bowls that were wet between the stacked bowls and 23 wet glasses that were upside down and an entire tray of glasses that were stored upside down that had condensation on the inside. The rack contained a stack of wet glass bowls, when taken off the rack and tipped to the side a small amount of water drained out. A stack of 4 divided plates contained visible water and one of the sanitized plates contained dried food debris. CDM verified the dishes were wet, and explained dishes were supposed to be dry prior to putting them away. CDM was not aware how long the dishes had	F 371	Facility failed to ensure sanitary dish storage, and failed to develop and implement a policy for safe food handling of leftover foods. CDM met with all dietary staff on 4/17/15 to review dietary policies and develop new standards, including: A. All foods are labeled with date of opening, per policy, by staff member opening item. Starting on 4/17/15 the freight person will be assigned by CDM to audit freezer and refrigerator. No product remains on shelf if beyond 7 days of opening. (4/17/15 CDM) CDM will audit weekly for 12 weeks. B. CDM ordered new dish rack which arrived on April 30th and are now in use. These new racks will assure that dishes and juice glasses are air dried (4/30/15 CDM) C. On 4/22/15 Maintenance staff moved knife rack to kitchen wall above sinks, where it will remain. D. On 4/17/15 a new policy was developed, by CDM for leftovers, which states that no amount under 50 servings will be saved. If 50 or more servings saved, the standards of cooling will be using shallow pans with maximum depth of two inches for dense foods and 3 inches for thin foods. Ice bath will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 371	Continued From page 46 been stored on the dry racks. Sharp knives were stored in a knife holder attached to the side of a preparation table. The bottom of the knife holder was not enclosed. The knife holder was 8 inches off of the floor. A knife was removed from the holder and found to be heavily soiled with gelatinized yellow debris as well as dried debris. CDM verified knife was dirty. During an interview on 4/16/15, at 10:29 a.m. in answer to the question " What is your process for handling leftover foods?" the CDM explained if there was more than 12 servings of leftovers they would put in shallow pans and placed in the refrigerator to be used within the next few days. The CDM stated they did not take temperatures during the cooling process. The CDM was not aware of the procedure to ensure safe temperatures and times for cooling left overs. During an interview on 4/16/15 at 10:42 a.m. the same question was posed to cook (C)-A. C-A stated leftovers were placed in shallow pans and then placed in the cooler. C-A stated they do not take temperatures during the cooling process. C-A was unable to explain the safe handling to prevent food borne illness for cooling leftover foods. C-A stated the leftovers are then used for the second choice entrée at the next day ' s meal. C-A stated temperatures of second choice foods were not taken after reheated or recorded and further explained not recording those temperatures had not ever been done. On 4/16/15 at 10:45 a.m. the CDM stated there was not a policy/procedure for safe handling for leftover foods other than facility policy Infection Control (pertaining to dietary). This policy read, "Leftover foods will be placed in seamless, covered containers, labeled and dated and stored immediately in cooler. Only 4 inches in depth if hot or protein food.", and " leftover foods placed	F 371	used and temps will be taken until cooled to 140F □ 70F. All staff in dietary was instructed in this method on 4/17/15 by CDM. CDM will audit weekly for 12 weeks. E. On 4/17/15 CDM developed a temperature log for all second choice menu items, and trained dietary staff to use. CDM will audit for 12 weeks. Director of Nursing and Assistant Director of Nursing will be responsible for reeducation of policy and procedures for all nursing staff on 5/15/15/ effective date of correction is 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 371	Continued From page 47 under refrigeration must be consumed within 72 hours, after which time they will be discarded ..." Food temperature logs were reviewed from January through March 2015. The logs did not reflect any second choice entrée temperatures were obtained even though they were offered at meal time. Facility policy Food Storage (no date) read, "Food which have opened or prepared will be placed in an enclosed container, dated, and labeled. Expiration dates on all foods in the storeroom as well as the refrigerator will be checked on a regular basis and food/fluids which have expired discarded." Facility policy Dishwashing signed 2/2012 read, "Dishes are to air dry before storage or use. Dishes/glassware will be protected from contamination by enclosed storage or being covered in a dish lowerator." Facility policy Infection Control (Dietary function, not dated) read, "Food Service and Ware Washing 9. All dishes, silverware, etc. Will be stored in clean, dry, and enclosed storage."	F 371		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet	F 425		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 425	Continued From page 48 the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure accurate labeling of medications for 3 of 6 residents (R104, R14, R57) observed to receive medication during the survey, and 1 of 5 residents (R10) reviewed for unnecessary medication use. Findings include: R104's admission Minimum Data Set (MDS), dated 4/1/15, identified R104 had intact cognition, and received a daily insulin injection. R104's Orders from Doctor fax, dated 3/31/15, identified an order of, "[change] Novolog rapid acting insulin dosing to 2 units/15 gram carb. [carbohydrates] with meals, per resident." During observation of medication administration on 4/14/15, at 11:25 a.m. licensed practical nurse (LPN)-H prepared insulin for R104 in the medication room on the second floor of the facility. The Novolog insulin vial was provided to the surveyor and read, "INJECT 1 UNIT SUBCUTANEOUSLY FOR EVERY 15 GRAMS EATEN THREE TIMES DAILY." There was no modification to the label to alert staff to refer to the updated order on 3/31/15 physician orders.	F 425	Facility did not identify the change in medication label on an insulin vial and eye drop vial. Facility was administering the medication according to the physician□s order but did identify the change on the medication label. On 4/15/15 Assistant Director of Nursing updated all medication labels for affected residents immediately by drawing a line through the medication label and indicating a order change per facility policy. Assistant Director of nursing educated staff in regards to order changes and medication labels to prevent labels being inaccurate. Facility will follow policy and procedure by drawing a line through the medication label and indicating that there is a medication order change. Charge nurse went through medication carts to make sure that medication labels matched labels on 4/15/15 for all residents. Facility policy and procedure states that the labels will be corrected with the next ordering of the medication. Facility will audit medications bi weekly for 90 days to make sure that solutions are being sustained until approval from QA committee. Audit will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 425	Continued From page 49 LPN-H prepared the insulin according to the physician order, and administered it to R104. When interviewed on 4/14/15, at 11:28 a.m. LPN-H stated she did not read the label prior to preparing the insulin for injection, "I'll be honest with you, I did not look at that." Further, the "label is incorrect" and she would notify the pharmacy to obtain a new label in order to reduce the risk of a medication error. R14's quarterly MDS, dated 1/21/15, identified R14 was cognitively intact. R14's Discharge Medication List, dated 11/15/14, identified an order of, "OCULAR [eye] LUBRICANT (THERATEARS OPHTHALMIC SOLUTION) 1 DROPS, EYES (BOTH), FOUR TIMES A DAY." During observation of medication administration on 4/14/15, at 11:41 a.m. LPN-H prepared the eye drops and provided the container to the surveyor which read, "INSTILL 1 DROP IN BOTH EYES FOUR TIMES DAILY AS NEEDED FOR DRY EYES." There was no modification to the label to alert staff to refer to the physician orders updated 11/15/14. When questioned regarding the label and order discrepancy, LPN-I stated the label was not accurate, and she would notify the pharmacy. Further, LPN-I stated the night shift nurse is assigned to check for correct medication labeling, however since the facility had cut staffing hours, it was becoming harder to get it completed. R57's annual MDS, dated 2/11/15, identified R57 was cognitively intact, and took a daily anti-anxiety medication. R57's Physician Orders Sheet, dated 4/7/15, identified an order of, "Ativan [anti-anxiety medication] 0.5 mg [milligrams] tab	F 425	be completed by charge nurse and nursing administration. Director of Nursing and Assistant Director of Nursing produced reeducation material for each staff member, effective date of correction is 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 425	Continued From page 50 [tablet] 1/2 [one half] per PEG [Percutaneous Endoscopic Gastrostomy] tube BID [twice a day]." During observation of medication administration on 4/16/15, at 7:50 a.m. registered nurse (RN)-A prepared R57's at a mobile cart. The Ativan package was provided to the surveyor and read, "LORAZEPAM [Ativan] TAB 0.5 MG ... TAKE 1 TABLET VIA [by way of] PEG TWICE DAILY." There was no modification to the label to alert staff to refer to the physician orders dated 4/7/15 for use of half tablet of Ativan. When questioned regarding the label and order discrepancy, RN-A stated the label was inaccurate, and the facility had been faxing the pharmacy in order to get it changed for over a month, but it had not been completed yet. Further, RN-A added, "Our protocol is to get a new label." R10's Humalog medication label on the vial currently in use read, "inject 7 units subcutaneously in the morning; inject 6 units subcutaneously at noon." The insulin had a dispense date of 4/2/15. R10 had diagnosis that included diabetes mellitus. R10's physician orders signed & dated 2/10/15, revealed orders for Humalog insulin seven (7) units at 8:00 a.m., five (5) units at 12:00 p.m., and three (3) units at 6:00 p.m. The physician order for Humalog insulin five (5) units at 12:00 p.m. had a start date of 6/28/14. The physician order for Humalog insulin three (3) units at 6:00 p.m. had a start date of 2/11/14. However, the label for Humalog should have read six (6) units at 12:00 p.m. or noon. Also the label did not include the 6:00 p.m. dose of three (3) units of Humulin insulin.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 425	Continued From page 51	F 425		

Document review of the facility medication administration record for 4/1/15 through 4/14/15, revealed R10 received insulin as ordered.

Document review of blood sugar reports faxed to physician dated 11/20/14, 12/3/14, 1/28/15, 2/4/15, 2/25/15, 3/4/15, and 3/25/15, each identified R10 received Humalog insulin doses as ordered.

During interview on 4/16/15, at 9:30 a.m., registered nurse (RN)-E verified the insulin label dispense date of 4/2/15 and that the label directed Humalog 7 units in the morning and 6 units at noon. During interview at that time, RN-E verified the insulin label did not include three units at 6:00 p.m., as physician ordered. RN-E verified the label did not include the current physician order for five units at 12:00 p.m. RN-E stated she expected nurses to notify the pharmacy when there were label discrepancies.

When interviewed on 4/16/15, at 9:24 a.m. the dispensing pharmacist (P)-A stated incorrect medication labels should be immediately reported to the pharmacy so they can be corrected, and nursing staff should place a "directions changed" sticker on the label to reduce the risk of medication error until they can be changed.

A facility Pharmaceutical Services policy, dated 3/1999, identified, "Medication inventory shall be periodically inspected to insure the proper storage of an accurate, current, non-expired drug supply for each resident." Further, the policy added, "Medication change orders resulting in new directions on the container label shall necessitate a new label", and listed a procedure including, "Nurse removes the respective container of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 425	Continued From page 52 medication and crosses the existing label with a large black line or X."	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the consultant pharmacist identified irregularities for psychoactive medication use and that the physician follows up on recommendations for of 5 residents (R83) reviewed for unnecessary medications. Findings include: R83 was admitted to the facility on 5/23/2014 according to the facility's admission record. R83's facility Diseases Index Report revealed R83 was admitted to the facility with diagnoses that included but were not limited to dementia with behavioral disturbance and depressive disorder. The diagnosis of Schizophrenia with acute exacerbation was added on 5/30/14 and the diagnosis of paranoia agitation was added on 6/27/14. R83's quarterly Minimum Data Set (MDS) dated	F 428	R 83 was found to not have proper target behavior for the use of an antipsychotic and mood stabilizing medication. Facility was not monitoring R 83□s diagnosis of paranoia on the behavior monitoring sheets. Previous nurse case manager is no longer with the facility, on 4/16/15 new nurse case manager corrected behavior monitoring sheets and care plan to accurately track diagnosis behaviors. Education was done by assistant DON on 4/16/15 in regards to importance of tracking target behaviors with all antipsychotic and mood stabilizing medications. Currently all antipsychotic and mood stabilizing medications along with their target behaviors are address at each care conference and quarterly with consultant pharmacist reviews. As of	5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 428	Continued From page 53 10/29/14 indicated severe cognitive impairment and displayed behavioral symptoms not directed at others one to three days during the assessment period. The MDS revealed a staff assessed mood monitoring (PHQ-9) score of 10 indicating moderate depressive symptoms. Signed physician orders dated 4/12/15 included Risperdal (antipsychotic medication) 0.5 mg by mouth once per day for diagnoses of paranoia/agitation. The original start date was 6/23/14 and was administered twice per day; order was changed to 0.5 mg once per day in November 2014. There was no indication that the resident was not assessed for potential extrapyramidal side effects after the initiation of Risperdal June 2014 nor was there side effects assessed after the dose reduction November 2014. There was no resident specific target behaviors identified to determine if the Risperdal was affective or not. Signed physician orders dated 4/12/15 included Depakote (mood stabilizing medication) 250 mg by mouth once per day. The original start date had been 7/30/14. There was no information in regards to attempting a gradual dose tapering of the Depakote since the medication was started on 7/30/14. There was no resident specific target behaviors identified to determine if the medication was affective or not. Signed physician orders dated 4/12/15 included Trazodone (antidepressant medication which is used for insomnia) 50 milligrams (mg) by mouth before bed and 50 mg by mouth as needed if not asleep in one hour. The start date of Trazodone was 6/17/14. The as needed order was added on 7/23/14. The pharmacist recommended reducing the Trazodone to 25 mg 7/24/14 due to possible side effects of resident falling. The Trazodone was not reduced at this time and there was no	F 428	correction date the pharmacist□s psychoactive drug review every six months the facility will also provide documentation for state requirements for physicians with the review. Director of Nursing and Assistant Director of Nursing will be responsible for reeducation of policy and procedures for all nursing staff on 5/15/15/ effective date of correction is 5/14/15. R 83 was found to not have proper target behavior for the use of an antipsychotic and mood stabilizing medication. Facility was not monitoring R 83□s diagnosis of paranoia on the behavior monitoring sheets. New Drug review was perfumed by nurse case manager and sent to primary physician for review. Previous nurse case manager is no longer with the facility, on 4/16/15 new nurse case manager corrected behavior monitoring sheets and care plan to accurately track diagnosis behaviors. Nurse case manager reviewed residents with antipsychotic and mood stabilizing medications to ensure no further issues. Education was done by assistant DON on 4/16/15 in regards to importance of tracking target behaviors with all antipsychotic and mood stabilizing medications. Currently all antipsychotic and mood stabilizing medications along with their target behaviors are addressed at each care conference and quarterly with consultant pharmacist reviews. As of correction date the pharmacists psychoactive drug review every six months the facility will also provide documentation for state requirements for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 428	Continued From page 54 gradual dose taper done since ordered on 6/17/14 or a physician ' s justification as to why the gradual dose tapering was contraindicated at this time. Signed physician orders dated 4/12/15 included Zoloft 100 milligrams (mg) every day for depression. The original start date of Zoloft was pre-hospitalization. The physician had ordered Zoloft be reduced to 50 mg per day times one week in July 2014 then it returned to current dose of 100 mg per day. There was no gradual dose reduction attempted twice in the first year being on Zoloft nor was there a physician ' s justification as to why it was contraindicated to reduce the Zoloft. A pharmacist note dated 8/8/14 included "family has declined this med change" as a reason a gradual dose taper was not attempted. However, this is not an acceptable reason for not attempting a dose reduction. Also the Zoloft lacked specific resident mood and/or behaviors to monitor to determine if the Zoloft was affective. The only behavior monitoring tracking form that was evident in the medical record was from March 2015 and had been used to monitor depression. The target behaviors indicated were crying/restlessness. The interventions that were listed were generic and not resident specific. The documentation reflected 1 episode of crying and restless for the month of March. During an interview on 4/15/15 registered nurse (RN)-E verified the facility had not developed target behaviors and interventions and monitoring had not been performed. RN-E verified there were not individualized interventions for target behaviors of restlessness and crying for mood monitoring for depression. RN-E also verified there was no evidence in the medical record of any follow up with the psychologist for possible medication regimen adjustment as a result of the	F 428	physicians with the review on all residents. Nurse case manager will fill out quarterly drug review on all residents with antipsychotic and mood stabilizing medications. Consulting pharmacist's form with drug review will be reviewed by primary physician and audited for following policy and procedure by director of nursing this will be on going checking for medication irregularities. Director of Nursing and Assistant Director of Nursing provided reeducation material for all staff; effective date of correction is 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 428	Continued From page 55 pharmacy recommendation on 2/13/15. A facility policy Pharmaceutical Services read, "nurses shall monitor the administered medications dose response...nurses shall monitor for beneficial therapeutic response, adverse drug response, common side effects, lack of therapeutic response, lack of resident response." and "Monthly the nursing staff shall chart a summary of observe dose-response of the administered medications." and "The consultant pharmacist shall monitor all aspects of medication utilization."	F 428		
F 441 SS=E	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 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 441	Continued From page 56 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 staff with signs and symptoms of potentially communicable disease did not provide services for residents which had potential to affect 18 of 34 residents residing on the second floor of the facility, and to ensure staff wore appropriate protective equipment during a blood glucose check for 1 of 2 residents (R35) observed to have their blood glucose checked during the survey. In addition, the facility failed to ensure outside volunteers passed water to residents using a sanitary method which had potential to affect all of the residents on the second and third floors who are able to drink water. Findings include: During observation on 4/15/15, at 7:27 p.m. licensed practical nurse (LPN)-I was standing at a mobile medication cart in the hallway preparing medications for the North and South wings of the second floor. LPN-I had audible congestion, and	F 441	Facility failed to ensure an ill staff member did not provide services. Once facility found out employee was ill facility called and replaced employee. On 4/15/15 employee LPNI was reeducated on the policy and procedure by director of nursing in regards proper infection control protocol for sick employees. All employees will continue to be educated with Educare annually and as needed on infection control. Staff did not wear proper personal protective equipment while administering a blood glucose test. All residents who were cared for by employee were monitored by Interdisciplinary team to track any infection control concerns. Also county MRCI volunteers did not wear gloves or disinfect their hands between administering water mugs to residents. On 4/16/15 assistant director of nursing educated staff on proper infection control techniques in obtaining blood glucose.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 441	Continued From page 57 stated she had a sore throat adding, "My whole head hurts." She had developed these symptoms, including a fever, on 4/14/15. LPN-I checked her temperature, and had a fever of 99.2 degrees Fahrenheit (F). Further, LPN-I stated she should not be working with residents as she was ill, "If I have a fever, I probably shouldn't be here." When interviewed on 4/15/15, at 7:34 a.m., registered nurse (RN)-D stated staff members are not to be working if they are ill and/or have a fever, "That's just the policy." During continued observation of LPN-I, on 4/15/15 at 7:37 a.m., she continued to prepare medication for residents, despite identifying herself as having a fever and being ill. LPN-I did not wear any gloves or mask during the medication preparation, and stated she would notify the director of nursing (DON) or scheduler when they arrive at the facility later in the morning stating, " I will talk to them." When interviewed on 4/15/15, at 8:12 a.m. RN-F stated a staff member who had nasal type symptoms or fever should not be working with the resident population, and should be sent home adding, "I think it's just kind of a common sense thing." During additional observation of LPN-I on 4/15/15 at 8:41 a.m., she prepared and administered a cup of oral medications to R18. LPN-I did not have any gloves on, or face mask in place to reduce the risk of infection transmission as she passed the medications. LPN-I continued to prepare and pass medications to residents, despite being identified as having a fever and	F 441	On 4/21/15 volunteer director educated MRCI volunteer and all support staff on proper technique of hand washing and glove wearing. Education included that each volunteer will put on a new pair of gloves and hand sanitizer in between each resident room. A box of gloves, hand sanitizer and garbage bags were added to each water cart. Infection control orientation will be provided to volunteers and employees will receive infection control education annually through Educare, at time of hire and as needed. Facility will perform CBG audits bi-weekly to make sure infection control/PPE techniques are being followed. Human Resources can monitor for sick employees and their return to work dates biweekly. Volunteer coordinator will audit all volunteers biweekly to ensure infection control techniques are being followed. All audits will continue until approved by QA committee. Director of Nursing and infection control nurse have provided reeducation to all staff; effective date of correction is 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 441	Continued From page 58	F 441		

being ill, to residents until 9:30 a.m. when she gathered her belongings and left the floor.

A facility Employee Health Infection Control policy, dated 4/29/14, identified a purpose including, "To reduce the potential transmission of infectious agents to the physically or medically frail resident or to co-workers." Further, the policy identified a procedure which included, "No employee may report to work with a fever...or other contagious disease until you have been treated for 24 hours."

LACK OF PROTECTION DURING BLOOD GLUCOSE CHECK:

R35 was observation on 4/14/15, at 10:54 a.m. when licensed practical nurse (LPN)-H pierced R35's finger with a single use lancet (device which contains a needle that is used to expose blood) and squeezed R35 ' s finger with her bare hands exposing blood. LPN-H obtained a sample on the testing strip of the glucometer, and returned to the medication cart. LPN-H did not have any gloves on during R35's blood glucose check.

When interviewed on 4/14/15, at 10:55 a.m. LPN-H stated she should have worn gloves to check R35's blood glucose, but wanted to let R35 get to the lunch meal, "Just hurry up and do it so she can go."

During interview on 4/16/15, at 10:14 a.m. registered nurse (RN)-F stated all nurses are trained to wear gloves when performing blood glucose monitoring for residents, and LPN-H should have had gloves on when checking R35's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 441	Continued From page 59 blood glucose. A facility Blood Glucose Monitoring policy, dated 4/29/14, identified a procedure which read, "Put on non-sterile gloves" prior to obtaining a blood sample. LACK OF SANITARY WATER PASS TO RESIDENTS: During an observation of the third floor morning water pass performed on 4/15/15 by volunteers from an outside agency, revealed a lack of hand hygiene practices to reduce the risk of possible cross contamination and spread of infection to residents. On 4/15/15, at 9:27 a.m. Volunteer (VOL)-C entered resident room 355, palmed (entire palm of hand placed on top of lid to open) the lid of the water cup; VOL-C hand touched the drinking area of the lid where the resident would put lips to sip water from cup. VOL-C carried the cup to the restroom sink, and tipped the cup upside down placing the rim of the cup on the bathroom sink, then put the lid on after touching the outside of the sink and the water faucet, then carried it out of the room and handed it to VOL-A. VOL-A palmed the lid; VOL-A again touched the drinking area on lid. VOL-A filled the cup with water via water cooler on a cart. VOL-A then replaced the lid of the cup and touched the drinking area again. VOL-C stood on the other side of VOL-A and waited for cup to be filled and was observed to touch face, hair, and water cart. VOL-C then un-wrapped a drinking straw and touched both ends. VOL-A handed VOL-C the water cup. VOL-C placed the straw in the cup and returned water to room 355. On 4/15/15, at 9:34 a.m. VOL-D entered resident room 310. VOL-D picked up the water cup by the lid and removed the straw. Once the lid was	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 441	Continued From page 60	F 441		

removed, VOL-D carried the cup to the restroom with her forefinger inside the cup holding onto it. VOL-D dumped the water out of the cup, touched the bottom of the cup to the drain grate in the sink, and then palmed the lid and put it back on. VOL-D then returned to the cart that was outside of the room and handed the water cup to VOL-A. VOL-A then palmed the lid; touched the drinking area. VOL-A then filled it with water and placed the lid back on; touched the drinking area of the lid. VOL-D had been standing next to the water cart touched her clothes and the water cart, then unwrapped and touched both ends of the straw. VOL-D returned the water glass to room 310.
No observations were made of volunteers practicing safe hand hygiene during these observations, the water pass was ceased and staff educated on lack of sanitary practice used. All residents had clean cups exchanged for soiled cups.
During an interview on 4/15/15, at 9:36 a.m. registered nurse (RN)-F in charge of infection control stated expectations of hand hygiene during water pass and the water pass had not been performed in accordance with recommended infection control practices. RN-F stated volunteers were required to go through orientation, which included infection control. RN-F stated she did not provide orientation on infection control to volunteers. RN-F was not aware of what topics were covered under the infection control portion of orientation. RN-F stated the activities director provided orientation.
During an interview on 4/15/15, at 9:39 a.m. activities director (AD)-I verified she had been in charge of the coordination of the volunteers from the outside agency and was responsible for orientation to the facility that included the infection control portion. AD-I explained, the volunteers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 441	Continued From page 61 passed water for the second and third floor residents. AD-I stated the infection control portion of orientation did cover hand hygiene. AD-I verified volunteers that were present had received orientation. AD-I stated, the volunteer's supervisor were supposed to be trained as well to provide oversight and guidance when needed. The facility's Volunteer Orientation Checklist dated 6/14/00 read, "Infection control (hand washing procedure)." A policy pertaining to hand hygiene was requested and not received.	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 food service equipment in a sanitary manner for 63 out of 64 residents. This had the potential to effect 63 out of 64 residents that resided in the facility. Findings include: During the tour of the facility's kitchen guided by the certified dietary manager (CDM) on 4/13/15, at 3:10 p.m. The convection oven tops had a layer of gray dust, the faces or fronts of the ovens had an overall smeared with debris appearance. They had a layer of black greasy appearing substance and crumbs of dry debris on the stainless steel below the oven door. The inside bottom of the ovens showed rust areas with a	F 465	Facility failed to maintain food service equipment in sanitary manner. All affected equipment was cleaned immediately by dietary staff by direction of CDM on 4/17/15. Total kitchen was deep cleaned the week of April 20th under supervision of CDM A. Cleaning schedule was revised by CDM listing every piece of equipment and assigning specific duties to specific dietary staff members. CDM reviewed with all staff the week of April 19th to assure that each person understood cleaning process and products to be used. CDM will audit weekly for 12	5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 62 thick layer of dried black debris build up. The ovens located next to the convection ovens had oven racks set on top of oven and underneath the racks the oven surfaces had dried debris and dust. The fronts of the ovens were smeared with debris in appearance. The large mixer had dried debris and dust on the legs, where the bowl connects to the mixer, and around the legs of the mixer. The area where the beater would be attached showed yellow congealed fluid. The combination grill/oven faces were soiled and had dried food debris underneath. A long preparation table that had small appliances including a microwave, a food processor, a mixer and a blender on top was cluttered and had food debris along the back edge. The microwave had small area of rust and built up of food debris on the left hand side near the door latch. The underside of the small mixer where the beater would be attached showed a buildup of dark debris. The floors underneath the sink, the long preparation table (table with small appliances), and the dishwasher area were extremely soiled with debris. The mop boards or base boards that surrounded the kitchen were soiled with a black buildup of debris. The grouted areas of the tile floor around the baseboards showed black buildup of debris too. During a kitchen tour on 4/16/15, at 10:30 a.m. (two days later) the same findings as outlined were observed. During an interview on 4/16/15, at 11:26 a.m. CDM stated a cleaning schedule is used and expected staff to follow the schedule. CDM explained the maintenance department pressure washed the floors once a month and sometimes once a week with a floor machine.	F 465	weeks. A disadvantage is that the grout in the kitchen is the color black. The floor cleaning schedule was reviewed with maintenance and CDM on 4/17/15. Kitchen floors are cleaned every other Friday, with the 2nd Friday being a power wash. One was done on 4/17/15. CDM will do weekly audit and report to maintenance director if additional washes needed. Effective date of correction is 5/14/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 63 The facility cleaning schedule gave direction to staff to clean work area daily. The cleaning schedule did not give details of surface areas or equipment in the "work area" that may need daily cleaning and upkeep.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/28/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENT	**610 SUMMIT DRIVE FAIRMONT, MN 56031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on APRIL 28, 2015.. At the time of this survey, Building 01 of Lakeview Methodist Health Care Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

Lakeview Methodist Health Care Center was constructed as follows:
Building 01 consists of the 1963, 1978 and 1993 buildings. Building 01 is three stories in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction;
Building 02 represents the 2000 addition, and consists of a chapel, main entrance, business offices, mechanical room and a link to an assisted living facility. This addition is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction.

2-hour fire wall assemblies separate both the buildings of Type II(111) construction from the addition of Type V(111) construction, and, the nursing home from an assisted living facility. Opening protectives consist of labeled, self-closing, positive latching, 90-minute fire door assemblies.

In accordance with NFPA 101 (2000) Chapter 19,

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/28/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENT	**610 SUMMIT DRIVE FAIRMONT, MN 56031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Table 19.1.6.2, a three-story building of Type V(111) construction is not permitted. As such, the facility was surveyed as two-buildings, and two Form CMS-2786R booklets were completed. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 85 beds and had a census of 62 at time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **02 - THE CHAPEL** B. WING _____	**04/28/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENT	**610 SUMMIT DRIVE FAIRMONT, MN 56031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on April 28, 2015. At the time of this survey, Building 02 of Lakeview Methodist Health Care Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

Lakeview Methodist Health Care Center was constructed as follows:
Building 01 consists of the 1963, 1978 and 1993 buildings. Building 01 is three stories in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction;
Building 02 represents the 2000 addition, and consists of a chapel, main entrance, business offices, mechanical room and a link to an assisted living facility. This addition is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction.

2-hour fire wall assemblies separate both the buildings of Type II(111) construction from the addition of Type V(111) construction, and, the nursing home from an assisted living facility. Opening protectives consist of labeled, self-closing, positive latching, 90-minute fire door assemblies.

In accordance with NFPA 101 (2000) Chapter 19,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **02 - THE CHAPEL** B. WING _____	**04/28/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENT	**610 SUMMIT DRIVE FAIRMONT, MN 56031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Table 19.1.6.2, a three-story building of Type V(111) construction is not permitted. As such, the facility was surveyed as two-buildings, and two Form CMS-2786R booklets were completed. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 85 beds and had a census of 62 at time of the survey.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
May 4, 2015

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, Minnesota 56031

Re: Enclosed State Nursing Home Licensing Orders - Project Number S54280024

Dear Ms. Barnes:

The above facility was surveyed on April 13, 2015 through April 16, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted 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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On April 16, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed for 1 of 1 resident (R97), who was dependent of staff to place hearing aids for use. Findings Include: R97's quarterly Minimum Data Set (MDS) dated 3/4/15 indicated R97's ability to hear was adequate with the use of a hearing aid. R97's care plan, dated 03/15/13, read, "...Resident is able to communicate needs ...hearing is adequate with the use of bilat [bilateral] aides." In addition it directed staff to place hearing aids daily in the morning and the nurse was to check to ensure they were functioning properly and batteries were charged to make sure hearing aids were working. On 4/13/15 at 7:12 p.m. during an interview with R97 and her friend (FR)-A present, R97 was	2 565	Completed on 5/14/15	5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 3 observed to not have her bilateral hearing aids in place. FR-A stated R97's bilateral hearing aids are often not in when she comes to visit her. FR-A said she visits frequently during the week. On 4/16/15 at 9:30 a.m. R97 was observed to be sitting in her recliner in her room reading the newspaper and again her hearing aids had not been placed. On 4/16/15 at 9:32 a.m. licensed practical nurse (LPN)-H stated the nursing assistant who assisted R97 with morning cares was responsible for placing R97's hearing aids for the day. On 4/16/2015 9:38 a.m. during an observation LPN-H verified R97 did not have her hearing aids located in her ears and then LPN-H asked R97 if she would like to have her hearing aids placed in her ears and R97 stated, "Yes." LPN-H proceeded to placed R97's hearing aids in each ear and R97 thanked her. On 4/16/2015 at 10:03 a.m. social services (SS)-D stated her expectation was when staff was getting residents ready for the day their hearing aids should be placed. A care plan policy was requested and was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure resident care plan was followed. The director of nursing could inservice all staff to follow the resident care plan. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 4 (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to revise the care plan for 1 of 3 residents (R41) who had a decline in bladder continence over three month period of time. Findings include: R41 was admitted to the facility on 11/20/2014 according to the facility admission records with diagnoses that included but were not limited congestive heart failure, end stage lung disease, malaise, fatigue, and spinal cord myelodysplasia. R41's admission Minimum Data Set (MDS) dated 11/26/14 indicated no cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 15 and R41 required extensive assistance from one staff member for toileting. The MDS indicated R41 was occasionally incontinent of urine and received a diuretic medication. R41's medication administration record (MAR)	2 570	Completed on 5/14/15	5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 5 included Lasix (diuretic medication) 40 milligrams (mg) by mouth twice per day. R41's care plan initiated on 12/2/2014 indicated R41 was at risk for alterations in skin integrity related to decreased independence in mobility and exposure to moisture from urinary incontinence. The care plan identified history of incontinence and decreased awareness to void and read, "Resident is incontinent of urine occasionally ...has uterine prolapse and is at risk for urinary tract infection." The care plan failed to identify the amount of assistance R41 required for toileting. R41's significant change MDS dated 12/31/14 indicated R41 required extensive assist of one staff member for toileting, did not have a trial toileting program, was frequently incontinent of urine, and used a diuretic medication. However, the facility did not update R41's care plan to reflect the increase in urinary incontinence that had been coded on the significant change MDS. A communication that was written on the facility's Physician Orders form read, "Resident continues to refuse to get up out of bed for meals and visits with family. States she gets short of breath when she gets up. Resident will also void in her pad then put call light on to be changed immediately." The physician responded by ordering a trial of Klonopin for a week to "calm her down." R41's quarterly MDS dated 3/25/15 indicated R41 required extensive assist of one staff member for toileting, was always incontinent of urine, did not have a trial toileting program, and used a diuretic medication. Again the facility did not update the care plan to reflect the increase in urinary incontinence that had been coded on the quarterly MDS and the care plan did not reflect R41's pattern of intentional urinary incontinence to avoid	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 6 becoming short of breath during toileting. During an interview on 4/16/2015, at 2:36 p.m. registered nurse (RN)-E verified care plan had not been updated for R41 after decline in incontinence status. A facility policy pertaining to the care plan was asked for and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure resident care plan was revised as needed. The director of nursing could inservice licensed staff to revise resident care plan as needed. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.	2 900		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 7 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate care and treatment including comprehensive assessment, prescribed treatment, and resident education, for 1 of 3 residents (R21) reviewed with a current pressure ulcer. This resulted in actual harm for R21. Findings include: According to documentation of a body audit assessment conducted 12/16/14, R21 had current pressure areas to his heels, and was at risk for development of pressure ulcers. A Braden Scale for Predicting Pressure Sore Risk had been conducted 12/30/14, and R21 had been identified as at high risk for pressure ulcer development with a score of 19 out of 24. The Care Area Assessment (CAA) regarding pressure ulcers dated 12/30/14, identified R21's risk for breakdown and current heel ulcers, but did not identify any other pressure ulcers. A Resident Incident Report dated 12/30/14 at 11:30 p.m., indicated staff had identified a reddened area on the resident's coccyx and purplish-black areas on the resident's buttocks bilaterally with observed skin slough. Subsequently, a physician's visit note dated 12/31/14, indicated the resident had been seen at the clinic for evaluation of the areas on her buttocks. The physician's documented plan from the visit note included: "PLAN 1. Stage 1 pressure ulcer of the buttocks...I did discuss with her in detail that there is not an open wound...I did discuss with her that the mainstay of treatment will be attempting to relieve the pressure on her buttocks. She did seem very reluctant to have any type of movement at all.	2 900	Completed on 5/14/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 8 She did become concerned once I discussed that these particular issues can get progressively worse if she does not follow wound care instructions..." R21 required hospitalization on 1/6/15, after she was noted to have a stage IV pressure ulcer on the coccyx. The hospital discharge summary indicated she had been readmitted to the facility on 1/14/15, with the use of a wound vacuum (VAC) system to treat the stage IV pressure ulcer. Although R21 had developed the stage IV pressure ulcer and had to be hospitalized, the facility had not completed a comprehensive reassessment of the resident's tissue after R21's return to the facility in order to determine what interventions to implement to promote healing of the pressure ulcers, and to help prevent further pressure ulcers from developing. An admission Minimum Data Set (MDS) dated 12/19/14, identified R21 as cognitively intact, required extensive assistance with transfers and bed mobility, had one current stage II pressure ulcer (the outer layer of skin and part of the underlying layer of skin is damaged or lost), and as remaining at risk for pressure ulcer development. Additional information documented on the CAA for pressure ulcers dated 12/30/14, indicated R21 had an "existing ulcer" on her left heel, required a special mattress, regular turning and repositioning, and needed staff assistance to move. In addition, the CAA documentation included: "Res [resident] is at risk for pressure areas r/t [related to] overall health issues, poor tissue perfusion, hx [history] of CA [cancer] / radiation." The CAA identified no need for referrals but directed staff to "proceed to care plan." The Resident Incident Report dated 12/30/14,	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 9 further included: "Res. [resident] has poor tissue perfusion, often refuses to lay [should be lie] down during the day, prefers to sit up in w/c [wheelchair]. Often refuses to turn/repo [reposition] when prompted. Educated res. on importance of relieving pressure to bottom, educated staff to document refusals consistently." R21's Nurse's Notes from 12/31/14 at 4:51 a.m. identified; "Resident interviewed regarding buttocks wound. Resident states that she does sit too much and admits to not laying down when she should. Observed area [with] nurse and aide. Purple area approximately 8 cm X 4 cm [with] a slightly open draining area at the top... Wound flow sheet was filled out and education to resident and staff about its condition and importance of relieving pressure while up in chair and in bed. Will apply new cushion to chair and air mattress to bed as interventions to help relieve pressure areas." When nursing assistant (NA)-D was interviewed about the pressure ulcer on 4/15/15 at 10:03 a.m. she stated, "It just showed up, shortly after she got here." NA-D also stated the staff help R21 reposition every two hours or as she requests. However, during a subsequent interview on 4/15/15 at 10:54 a.m., NA-D stated R21 had been resistive to repositioning since she had been admitted to the facility. Record review indicated the first time staff had addressed any reluctance with repositioning, and risks/consequences associated, had been on 12/31/14 after the coccyx ulcer had been identified. Additional documentation on the physician's progress report from 12/31/14, included: "...The	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 10	2 900		

patient will also be encouraged to stay out of her wheelchair and at times lying in her bed with turning every 2 hours to keep pressure off this affected area. We will also see if we can get her a cushion that will help also prevent direct pressure on this area..." The progress note also indicated to "return to clinic in approximately 3 weeks for repeat assessment unless any acute issues develop before hand."

A History and Physical (H&P) dated 1/6/15, indicated R21 had been admitted to the hospital on 1/6/15 for intravenous antibiotics and wound care. The note included: "She was seen here in clinic on 12/31, with a reddened area on her coccyx. Apparently no ulceration, her breakage of skin surface was noted at that time...she has developed an ulceration in the coccyx area...The patient has developed since 12/31, a deep coccyx ulceration with apparent probable undermining and a purulent malodorous discharge. There is surrounding erythema. There has been some discomfort associated with this. Apparently the patient has been very difficult to regarding-position." A consultation note from a consult conducted by a surgeon on 1/8/15, included: "...Patient has a poor medical condition. She has had radiation for her tumor and one has to assume that the skin in this area is compromised. Following her surgery, the patient was in the nursing home and developed an ulceration on her coccyx which has gotten considerably worse.

Following R21's readmission from the hospital, a 5 day PPS (prospective payment system) MDS, dated 1/18/15, identified R21 now had moderate cognitive impairment, continued to require extensive assistance with transfers and bed mobility, and now had one stage II pressure ulcer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 11 along with one stage IV pressure ulcer. R21's care plan, dated 1/28/15, identified R21 had fragile skin, a "heel ulcer present on admission", and "often refuses to lay [should be lie] down, get off bottom thru the day when staff prompt her to do so." A goal was identified of, "Resident will have area on heel + [and] coccyx healed by next review." Further, the care plan identified interventions which included, "Float heels when in bed", "Pressure reducing mattress & [and] cushion in w/c [wheelchair]", and "follow treatments for L/heel [left heel] + coccyx as per current orders - see tx [treatment] sheets." R21's medical record was reviewed, there was no indication a comprehensive pressure ulcer reassessment was completed despite R21 being hospitalized for the development of a stage IV pressure ulcer. The facility only completed a Braden Scale, which only identifies a numerical rating of low or high risk. There was no indication the facility changed their pressure ulcer interventions from the admission Braden Scale of 12/30/14, even though R21 had developed a stage IV ulcer on her coccyx. On 4/15/15, at 11:08 a.m. registered nurse (RN)-E and RN-F were interviewed regarding R21's pressure ulcer. They confirmed R21 had routinely refused repositioning since her admission however, the facility had not completed any education regarding risks of not being repositioned, until the breakdown on her coccyx. RN-F also stated R21 should have been comprehensively reassessed for pressure ulcer risks when she'd returned from the hospital. R21's Surgery progress note, dated 1/20/15, identified, "The patient [R21] underwent a	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 12 complex debridement of a coccyges decubitus ulcer [pressure ulcer] on January 12, 2015. Following this procedure, a VAC wound care device [uses medical foam and a small vacuum to create negative pressure on a wound or pressure ulcer which facilitates healing], was placed." A further Surgery progress note, dated 2/5/15, identified R21 was seen for "a stage 4 decubitus ulcer located in her coccygeal area", and, "The patient [R21] was last evaluated in Surgery Clinic on January 27, 2015 when she was noted to have an inadequately placed VAC unit, along with a small sponge within the large coccygeal decubitus ulcer." Further, the note identified, "additional instructions were given to the wound specialist at patient's [R21] nursing home." The dressing was not removed at the appointment, so the ulcer was not evaluated for undermining. A subsequent Surgery progress note, dated 3/23/15, identified R21's ulcer "is at the deepest along the left lateral and left inferior aspect of the wound", and, "No fistulas, tunneling or undermining noted." Further, the note identified, "I [nurse practitioner (NP)-A] did contact nursing home staff and talked with [LPN-B] in regards to the wound dressing...they had been advised approximate 2 weeks ago by [PT], to obtain a foam roping to place in the wound as the foam they have was not completely filling the open wound." A Medical Information Exchange Form, dated 3/30/15, identified R21 had been seen in the clinic on 3/30/15 for a "coccyx ulcer", and included a treatment which identified, "Continue [with] wound vac. Make sure to pack deep into left deep aspect of wound." R21's condition was identified as "stable" by the NP-A. A review of R21's Wound Flowsheets identified the following information:	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 13 On 4/2/15, the pressure ulcer measured 4 cm X 3 cm X 1 cm in size, was "healing", and listed a treatment of, "Continue current treatment." On 4/3/15, the pressure ulcer measured 4 cm X 3 cm X 0.8 cm in size, was "healing", and continued to identify, "Continue current treatment." On 4/8/15, the pressure ulcer measured 3 cm X 2 cm X 1.5 cm in size, continued as "healing", and for staff to "Continue current treatment." On 4/10/15, the pressure ulcer measured 4 cm X 2 cm X 1.5 cm in size, remained identified as "healing", and for staff to, "Continue current treatment." No undermining was identified on the flow sheets for R21's pressure ulcer. During observation of pressure ulcer care, on 4/15/15 at 1:29 p.m. RN-D removed a non-coil type wound VAC dressing and exposed a stage IV pressure ulcer on R21's coccyx. The wound was symmetrical in shape, with granulation tissue (beefy red tissue indicative of healing) and approximately 50 percent (%) slough tissue (necrotic tissue). The pressure ulcer had undermining on all sides of the wound. RN-D measured the wound using a paper tape measure that had been included in the new wound VAC kit. RN-D measured the opening of the wound at 3 cm (length) X 2 cm (width) X 1.5 cm (depth). However, RN-D did not measure the depth of the wound at its deepest point or use any measuring tool to identify the depth and degree of the pressure ulcer's undermining. RN-D opened a new VAC Granufoam Silver dressing kit and cut the foam down to the size of the ulcer opening, and applied it into the opening of the pressure ulcer. RN-D did not use a foam coil dressing, or pack the foam into the undermining of the ulcer. RN-D cut a new clear film, draped the ulcer using the film, and applied a new central disc piece that	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 14 attaches the dressing to the vacuum device. When interviewed immediately after the observation of pressure ulcer care, on 4/15/15 at 1:43 p.m. RN-D stated she last observed R21's pressure ulcer on 4/6/15 and it did not have any undermining at that time. RN-D cut the new piece of foam to better fit the wound today, but verified she did not pack the foam into the undermining of the wound as the physician had instructed in the progress notes. On asking RN-D if she had any education on the use and application of the wound VAC system she replied she had no formal education on the wound VAC system, only having knowledge of the device and dressings from, "What we learned in school." When R21 had the wound VAC placed, a physical therapist (PT)-A had come and performed education on how to complete R21's dressing change; however RN-D was unable to attend the demonstration. Further, RN-D stated she completed the dressing change as she had been shown by other nurses. During interview on 4/15/15, at 2:50 p.m. PT-A stated she had last seen the wound about a month prior when R21 had come to the clinic for an appointment with NP-A. The NP-A had written specific instructions for the nursing home staff to follow regarding the pressure ulcer treatment, including packing the undermining and tunnels of the wound using the VAC foam. PT-A stated R21 had come into the clinic (1/27/15) from the nursing home before with the dressing not completed correctly (in regards to the VAC wound dressing), so she (PT-A) had went to the nursing home and completed a demonstration for two nurses on how to complete the pressure ulcer dressing change using the VAC foam and device. Further, the staff were left with instructions to call	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 15 her or KCI (the manufacturer of the VAC system) if they had questions. An interview was attempted with the NP-A on 4/15/15, at 2:59 p.m.; however she was, "out of the office for a period of time." During interview on 4/15/15, at 3:01 p.m. R21's surgeon's nurse, LPN-O was interviewed regarding R21's stage IV pressure ulcer. R21 was last seen on 3/30/15 by NP-A and the nursing home staff was advised to pack the ulcer and place the foam dressing "into the deepest aspect of the left inferior portion of the decubitus wound." When interviewed on 4/16/15, at 9:53 a.m. RN-E stated she had never changed R21's VAC dressing herself, but last observed R21's pressure ulcer in late March 2015 and at that time had not gotten a clear look at it. RN-E then added that R21 ' s pressure ulcer undermining should be packed with the VAC foam, "To heal from underneath, to the bottom up." RN-E was unaware what formal education had been completed for the staff regarding R21's dressing changes, but that staff should be measuring the wound from the deepest part. Further, RN-E stated the measurements collected of R21's pressure ulcer at the facility which were documented on the Wound Flowsheets were likely not accurate especially if the dressing changes were not completed as directed by the physician, it could have worsened R21's pressure ulcer, "Possibly, yea." The director of nursing (DON) was off campus on 4/16/15, and unavailable for interview regarding R21's pressure ulcer care and treatments.	2 900		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 16 A facility Wound Care policy, dated 4/30/14, identified a purpose of, "To prevent or minimize transmission of microorganisms during wound care procedures." The policy lacked any guidance for staff regarding when to explain the risks of failing to reposition timely, conduct assessment of a resident's risk for pressure ulcers, or for following physician guidance for wound care. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure comprehensive skin care, skin assessments, pressure ulcer treatments, and risk and benefit education provided. Director of nursing could inservice licensed staff to provide skin care services. The director of nursing could monitor staff compliance. The director of nursing could conduct audits and report the audit results to quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder	2 910		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 17 receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to comprehensively reassess the need for an individualized toileting program following a decline in urinary continence for 1 of 3 residents (R41) reviewed for urinary incontinence. Findings include: R41 was admitted to the facility on 11/20/2014 according to the facility admission records with diagnoses that included but were not limited congestive heart failure, end stage lung disease, malaise and fatigue, and spinal cord myelodysplasia. R41's admission Minimum Data Set (MDS) dated 11/26/14 indicated no cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 15 and R41 required extensive assistance from one staff member for toileting. The MDS indicated R41 did not have a trial toileting program and was occasionally incontinent of urine and received daily diuretic medication. R41's medication administration record (MAR) included Lasix (diuretic medication) 40 milligrams (mg) by mouth twice per day. R41's admission Bladder Evaluation indicated R41 was prescribed a diuretic, had mixed incontinence, had a history of incontinence,	2 910	Completed on 5/14/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 18 voiding pattern was upon rising and after meals, had 2-6 incontinence episodes per week, had a stage 1 pressure ulcer, and perception of need to void was diminished. R41's admission Bowel and Bladder Needs Evaluation revealed a score of 14 which indicated "Probable candidate for scheduled toileting program." R41's care plan initiated on 12/2/2014 indicated R41 was at risk for alterations in skin integrity related to decreased independence in mobility and exposure to moisture from urinary incontinence. The care plan identified history of incontinence and decreased awareness to void and read, "resident is incontinent of urine occasionally ...has uterine prolapse and is at risk for urinary tract infection." The care plan failed to identify the amount of assistance R41 required for toileting and an individualized toileting routine or program. R41's significant change MDS dated 12/31/14 indicated R41 required extensive assist of one staff member for toileting, did not have a trial toileting program, was frequently incontinent of urine, and used a diuretic medication. This was a decline from R41's admission MDS in bladder incontinence. However, the facility did not revise the care plan to reflect the increase in urinary incontinence that had been coded on the significant change MDS also the facility did not comprehensively reassess the need for a toileting program in the presence of an increase in urinary incontinence since the MDS completed on 11/26/14. A communication faxed to the physician in regards to bladder incontinence written on the	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 19 facility's Physician Orders form dated 2/25/15 and author was a registered nurse stated R41 continues to refuse to get up out of bed for meals and visits with family. States she gets short of breath when she gets up. Resident will also void in her pad then put call light on to be changed immediately. The physician responded to communication by ordering a trial of Klonopin for a week trial for something to calm her down. R41's quarterly MDS dated 3/25/15 indicated R41 required extensive assist of one staff member for toileting, was always incontinent of urine, and was not on a trial toileting program. The corresponding Bowel and Bladder Quarterly Review dated 3/31/15 read, "Resident remains incont. [incontinent] of urine, but cont. [continent of Bowel. At risk for UTI [urinary tract infection] R/t [related to] Urinary incont. and diuretic use." Again the quarterly assessment showed decline in bladder continence and again there was no revisions to the comprehensive care plan to address this decline. During an interview on 4/16/2015, at 2:36 p.m. registered nurse (RN)-E verified care plan had not been revised to address decline in continence for R41. Facility policy Bowel and Bladder Evaluation last revised on 4/29/14 read under POLICY: "Based on the resident's comprehensive assessment, the facility will ensure that each resident with bowel or bladder incontinence will receive appropriate treatment and services to restore as much normal bowel or bladder functioning as possible." Under PROCEDURE: it read,"1. Each resident will be assessed for 7 days for bowel and bladder	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 910	Continued From page 20 voiding patters on admission, quarterly, and with significant change with evaluation for feasibility in retraining for bowel and/or bladder control." "4. The resident's plan of care will be developed to address the issue, goals and appropriate interventions." SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure urinary comprehensive assessments were completed. The director of nursing could inservice licensed staff to conduct comprehensive assessments. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced	2 930		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 930	Continued From page 21 by: Based on observation, interview, and document review, the facility failed to ensure nursing staff checked placement of a gastrostomy tube prior to infusing medication and formula for 1 of 1 resident (R57) observed to have a tube feeding during the survey. Findings include: R57's annual Minimum Data Set (MDS), dated 2/11/15, identified R57 was cognitively intact, and received "51 percent (%) or more" of her total calories through the feeding tube. During observation of medication administration on 4/16/15, at 7:50 a.m. registered nurse (RN)-A had set up R57's medications and brought several cups of crushed oral medication into her room. RN-A applied a pair of non-sterile gloves in R57's bathroom, while R57 removed a clear gastrostomy tube from her clothing, laying it on a towel she placed on her lap. RN-A brought over a metal pole (to hang the bad of formula from), which contained a stethoscope, kneeled down beside R57 and poured the prepared medications into a 60 cubic centimeters (CC) syringe which she was attached to R57's gastrostomy tube. RN-A did not check the placement of R57's gastrostomy tube with the stethoscope hanging on the metal poll prior to infusing the medications. At 8:24 a.m. RN-A removed a new clear feeding bag from the package, and hung it up on the metal pole, and allowed the tube feeding formula to begin to infuse to R57's gastrostomy tube via gravity. Again RN-A did not check placement of the feeding tube with the use of a stethoscope after infusing R57's medications, or before beginning the infusion of her formula.	2 930	Completed on 5/14/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 930	Continued From page 22 When interviewed on 4/16/15, at 8:38 a.m. in regards to the feeding tube, RN-A stated she had not received any formal education on tube feedings since being hired at the facility, only having "what I got in the hospital" for training back in 2009. RN-A identified that R57, at times, had been noted to mess with her tubing. Further, RN-A stated she should have checked the placement of R57's feeding tube prior to infusing medication or formula "to make sure its in her stomach." During interview on 4/16/15, at 9:48 a.m. in regards to R57 ' s feeding tube, RN- E stated she was unaware of any formal education offered by the facility that was completed with nurses for feeding tubes. Further, R57's feeding tube should have been checked for correct placement prior to infusing medication or formula. A facility Enteral Nutritional Feeding policy, dated 4/29/14, identified a procedure which included, "Verify tube placement...before administering formula...before administering medications..." SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure nursing provided appropriate gastrostomy tube care. The director of nursing could inservice licensed staff to provide appropriate gastrostomy care. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 965	Continued From page 23	2 965		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently monitor weights and reassess for significant weight loss for 1 of 3 residents (R97) who had been reviewed for nutritional status. Findings Include: R97 was observed to eat her toast with two glasses of juice during breakfast on 04/15/2015 at 9:20 a.m. Resident said at this time she usually does not eat breakfast but said her toast tasted good. Again on 04/15/2015 at 12:27 p.m. R97 was observed to eat her lunch independently, ate 100% of her pork chop, 100% of her yogurt. 3/4 of yogurt. drank 4 ounces of Ensure clear, 10 ounces of milk, none of green beans, 3/4 of potatoes and gravy about 6 ounces of water. R97's quarterly Minimum Data Set (MDS) dated 3-4-15, identified diagnoses of anxiety disorder and depression. A brief interview for mental status (BIMS) score of 5 indicated severe cognitive impairment and needed assist of one	2 965	Completed on 5/14/15	5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 965	Continued From page 24 staff member for setup help only for eating. Review of R97's weights was documented as follows: 12-11-14: 117 (first weight taken at the facility) 12-24-14: 107 1-29-15: 106 R97 had an 11 lbs. weight loss between 12-11-14 and 12-24-14; this was 8.62% weight loss. The initial nutritional therapy assessment dated 12-8-15 read, "... Admit weight 129 lbs., Current weight 129 lbs., Recent weight 116 lbs. at Woodland Assisted Living ...,Edema on Admit; 2 plus edema in right arm...Diet Order: Regular...Portion size: regular...Nutrition Interventions started: none indicated..." R97's registered dietician (RD) progress note dated 12-8-14 read, "Initial assessment...Is on a regular diet ...Notice of admit form indicated she was recently 116# [pounds] at Woodland A.L. [assisted living], came to Lakeview at 129# [pounds]. Note post op [operative] hip edema is common. IDWR [ideal weight range] 121-149 # [pounds]. Current BMI [body mass index] 20.2 ...note documentation of edema in her right arm, which staff writes is new for her. Will monitor intakes and weights to determine if nutrition approaches are indicated. Will aim to hold her weight > [greater than] 115 lbs. and encourage intake of 50% or better at her meals." R97's intakes were reviewed from December 2014 to April 2015. Documentation of meal intake was not consistent, and there was no documentation found for meal intakes for the month of March 2015. R97's medication administration records (MAR)	2 965		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 965	Continued From page 25 were reviewed since admission. There was no documentation resident was to receive a nutritional supplement until 2-12-2015. At that time Kemps BID (twice a day) with meals was written on the top of the medication administration page. Nursing was not signing off when the supplement was given or documenting how much of the supplement was consumed by R97. The February 2015 MAR was reviewed and indicated on 2-17-15, R97 preferred Ensure clear and at this time the nurses started to document when the ensure clear was given, however did not document amount R97's consumed. R97's nutritional status care plan with a revised date 2-23-15 read, " At risk for nutritional status. DX [Diagnosis]; left hip FX [fracture], anxiety, depression. No chewing or swallowing difficulty. Able to feed self. IBWR [ideal body weight range]: 121-149# [pounds] Total protein and albumin levels are low. Res [resident] has lost wt. [weight]. Appetite is poor most meals; she says she is not hungry." Goal dated 2-23-15 read R97, " will drink 75% of supplement." Interventions included, " Diet: regular, Provide meals to 2nd floor dining room. Provide set up help as needed, offer snack between meals (added to care plan 2-23-15) Enc. intake at meals, esp [especially] of protein foods, 4 oz [ounces] Ensure clear TID [three times a day] (BID [twice a day] with meds at am/pm, [morning/evening] noon meal)." The supplement was added to the care plan on 2-13-15. R97's registered dietician progress note dated 12-13-15 read, "...note her weight is down to 117# [pounds] on 12-11-14, back to her usual weight. BMI [body mass index] noted to be low at 18.3. Will recommend staff see if she would accept 4 oz [ounces] Kemps [supplement] 1-2 x [times] a	2 965		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 965	Continued From page 26 day with med [medication] pass." R97's certified dietary manager (CDM) progress note dated 1-12-15 read, " will start 4 oz [ounces] Kemps BID [twice a day] with meds [medication] pass." R97's registered dietician progress note dated 2-23-15 read, "referred to dietary for poor intake. Was recently hospitalized d/t [due to] acute cholelithiasis (gall stones) ...small frequent meals recommended by the provider. Intake has been between 0-50%. Weight decreased to 107# [pounds] by late December 2014. Had stayed pretty stable before her hospital stay in feb [February]. Was 108# [pounds] on 2-12-15...was started on kemps but did not like it. Ensure clear was ordered instead on 2-17-15...Talked with R97 today about her appetite. She tells me she is never hungry and gets full quickly. She continues to tell me she doesn't want to eat breakfast or a mid-morning snack..." R97's medical record was reviewed and documentation revealed the physician was first notified of R97's weight loss on 2-23-15 by the RD when she requested an on order for ensure clear 4 ounces three times a day due to poor intake and weight loss. The facility was unable to provide any previous documentation of notification of R97's weight loss to the physician. On 4/16/2015 at 12:49 p.m. the certified dietary manager (CDM) stated she was aware of R97's weight loss and stated R87 was not a breakfast eater and agreed to have snacks in her room in a basket to eat throughout the day. The CDM stated nursing was responsible to document and monitor meal intakes and stated the RD monitored R97's weight on a monthly basis. The	2 965		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 965	Continued From page 27 CDM stated the protocol was when a nurse noticed a weight loss, they are to notify dietary and she would notify the RD. The CDM stated, " I know they didn't let me know about R97's weight loss, because I would have written it down on my sheet and I would have alerted the RD of the need to see the patient." The CDM stated residents should be weighed weekly on their bath day and this is not getting done. The CDM stated she had talked to the director of nursing (DON) to have him ensure residents are being weighed as this was a concern. The CDM stated, "There have been times when I have looked at a chart and I don't see a weight for the whole month. It is a big concern." The CDM stated, "There are so many places to document a weight, I think the staff is just not weighing them." The CDM again stated, " Nurses should have informed dietary of R97's weight loss and I know for a fact they did not inform us of her." The CDM stated the RD completed the first nutritional assessment, and monitored residents' weights on a monthly basis. The CDM verified there was no RD documentation for the month of January in the medical record. The CDM stated she became aware of R97's weight loss in February after the RD did her assessment on 2-23-15. On 4/16/15 at 2:03 p.m. registered nurse (RN)-F stated she found no additional weights or monitoring of the kemps supplement for R97. RN-F stated weights should be taken weekly with R97's bath and as the nurse was writing the weight in the chart, the nurse was to monitor the weights for weight gain, loss or stability. RN-F stated if the nurse noticed a weight loss they should increase frequency of weights being taken and notify dietary of the weight loss. RN-F verified this protocol was not followed for R97. RN-F verified R97 had a significant weight loss during	2 965		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 965	Continued From page 28 the first month of her stay in the facility. On 4/15/15 3:46 p.m. RN-F stated she was unable to find any documentation of notification to the physician regarding R97 weight loss until 2-23-15, when the RD requested an order for the clear ensure 4 ounces three times a day. Review of the Weighing Residents undated policy read, "Purpose: To maintain control of weight gain or loss ...Procedure...2. All residents are weighed on admission, weekly and per doctor's order. 3. Periodic weight checks should be made on residents with physical disorders, such as anorexia, dehydration, obesity, edema, or whenever otherwise indicated. 4. Nursing assistants should record the weights on the vitals sheets. 6. Notify physician of any significant weight loss or gain above 5 pounds gained or lost. 7. Consult with dietician if resident loses or gains weight in excess of normal range." SUGGESTED METHOD OF CORRECTION: The director of nursing and or the registered dietician can inservice staff on monitoring residents needs for nutritional meals and services. To maintain or prevent weight loss. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time	21025		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21025	Continued From page 29 and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility, failed to ensure safe refrigerated food storage and failed to develop and implement a policy and procedure for safe food handling of leftover foods. This had the potential to effect 63 out of 64 residents. Findings included: During kitchen tour on 4/13/15 at 3:10 p.m. guided by the certified dietary manager (CDM) observation revealed the following in the reach in cooler: 1 open bag of whipped topping approximately one half gone dated 3/4/15. The CDM verified the date on the bag of whipped topping and stated it should have been discarded. During an interview on 4/16/15, at 10:29 a.m. in answer to the question "What is your process for handling leftover foods?" the CDM explained if there was more than 12 servings of leftovers they would put in shallow pans and placed in the refrigerator to be used within the next few days. The CDM stated they did not take temperatures during the cooling process. The CDM was not aware of the procedure to ensure safe temperatures and times for cooling left overs. During an interview on 4/16/15 at 10:42 a.m. the same question was posed to cook (C)-A. C-A stated leftovers were placed in shallow pans and then placed in the cooler. C-A stated they do not take temperatures during the cooling process. C-A was unable to explain the safe handling to prevent food borne illness for cooling leftover foods. C-A stated the leftovers are then used for the second choice entrée at the next day's meal. C-A stated temperatures of second choice foods	21025	Completed on 5/14/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21025	Continued From page 30	21025		

were not taken after reheated or recorded and further explained not recording those temperatures had not ever been done.
On 4/16/15 at 10:45 a.m. the CDM stated there was not a policy/procedure for safe handling for leftover foods other than facility policy Infection Control (pertaining to dietary). This policy read, "Leftover foods will be placed in seamless, covered containers, labeled and dated and stored immediately in cooler. Only 4 inches in depth if hot or protein food.", and " leftover foods placed under refrigeration must be consumed within 72 hours, after which time they will be discarded ..."
Food temperature logs were reviewed from January through March 2015. The logs did not reflect any second choice entrée temperatures were obtained even though they were offered at meal time.
Facility policy Food Storage (no date) read, "Food which have opened or prepared will be placed in an enclosed container, dated, and labeled. Expiration dates on all foods in the storeroom as well as the refrigerator will be checked on a regular basis and food/fluids which have expired discarded."
Facility policy Dishwashing signed 2/2012 read, "Dishes are to air dry before storage or use. Dishes/glassware will be protected from contamination by enclosed storage or being covered in a dish lowerator."
Facility policy Infection Control (Dietary function, not dated) read, "Food Service and Ware Washing 9. All dishes, silverware, etc. Will be stored in clean, dry, and enclosed storage."

SUGGESTED METHOD OF CORRECTION:
The registered dietician could review and revise policies and procedures to ensure foods were served at safe temperatures. The registered dietician could inservice dietary staff to serve

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21025	Continued From page 31 foods at safe temperatures. The registered dietician could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21025		
21134	MN RULE 4658.0670 Supb. 2. Dishwashing; Sanitation, storage Sanitization; storage. All utensils and equipment must be thoroughly cleaned, and food-contact surfaces of utensils and equipment must be given sanitization treatment and must be stored in such a manner as to be protected from contamination. Cleaned and sanitized equipment and utensils must be handled in a way that protects them from contamination. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility, failed to ensure safe refrigerated food storage, failed to ensure sanitary dish storage, and failed to develop and implement a policy and procedure for safe food handling of leftover foods. This had the potential to effect 63 out of 64 residents. Findings included: During kitchen tour on 4/13/15 at 3:10 p.m. guided by the certified dietary manager (CDM) observation revealed the following in the reach in cooler: 1 open bag of whipped topping approximately one half gone dated 3/4/15. The CDM verified the date on the bag of whipped topping and stated it should have been discarded. During the tour of the dry dish storage area guided by the CDM, observation of the cup and	21134	Completed on 5/14/15	5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21134	Continued From page 32 bowl dry storage rack revealed a stack of 4 bowls that were wet between the stacked bowls and 23 wet glasses that were upside down and an entire tray of glasses that were stored upside down that had condensation on the inside. The rack contained a stack of wet glass bowls, when taken off the rack and tipped to the side a small amount of water drained out. A stack of 4 divided plates contained visible water and one of the sanitized plates contained dried food debris. CDM verified the dishes were wet, and explained dishes were supposed to be dry prior to putting them away. CDM was not aware how long the dishes had been stored on the dry racks. Sharp knives were stored in a knife holder attached to the side of a preparation table. The bottom of the knife holder was not enclosed. The knife holder was 8 inches off of the floor. A knife was removed from the holder and found to be heavily soiled with gelatinized yellow debris as well as dried debris. CDM verified knife was dirty. During an interview on 4/16/15, at 10:29 a.m. in answer to the question " What is your process for handling leftover foods?" the CDM explained if there was more than 12 servings of leftovers they would put in shallow pans and placed in the refrigerator to be used within the next few days. The CDM stated they did not take temperatures during the cooling process. The CDM was not aware of the procedure to ensure safe temperatures and times for cooling left overs. During an interview on 4/16/15 at 10:42 a.m. the same question was posed to cook (C)-A. C-A stated leftovers were placed in shallow pans and then placed in the cooler. C-A stated they do not take temperatures during the cooling process. C-A was unable to explain the safe handling to prevent food borne illness for cooling leftover foods. C-A stated the leftovers are then used for the second choice entrée at the next day ' s meal.	21134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21134	Continued From page 33 C-A stated temperatures of second choice foods were not taken after reheated or recorded and further explained not recording those temperatures had not ever been done. On 4/16/15 at 10:45 a.m. the CDM stated there was not a policy/procedure for safe handling for leftover foods other than facility policy Infection Control (pertaining to dietary). This policy read, "Leftover foods will be placed in seamless, covered containers, labeled and dated and stored immediately in cooler. Only 4 inches in depth if hot or protein food.", and " leftover foods placed under refrigeration must be consumed within 72 hours, after which time they will be discarded ..." Food temperature logs were reviewed from January through March 2015. The logs did not reflect any second choice entrée temperatures were obtained even though they were offered at meal time. Facility policy Food Storage (no date) read, "Food which have opened or prepared will be placed in an enclosed container, dated, and labeled. Expiration dates on all foods in the storeroom as well as the refrigerator will be checked on a regular basis and food/fluids which have expired discarded." Facility policy Dishwashing signed 2/2012 read, "Dishes are to air dry before storage or use. Dishes/glassware will be protected from contamination by enclosed storage or being covered in a dish lowerator." Facility policy Infection Control (Dietary function, not dated) read, "Food Service and Ware Washing 9. All dishes, silverware, etc. Will be stored in clean, dry, and enclosed storage." SUGGESTED METHOD OF CORRECTION: The dietician or Certified Dietary Manager could inservice all employees responsible for storage of	21134		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21134	Continued From page 34 dishes to store dishes that are dry and free from debris. TIME PERIOD FOR CORRECTION: Seven (7) days.	21134		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced	21390		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 35 by: Based on observation, interview, and document review, the facility failed to ensure staff with signs and symptoms of potentially communicable disease did not provide services for residents which had potential to affect 18 of 34 residents residing on the second floor of the facility, and to ensure staff wore appropriate protective equipment during a blood glucose check for 1 of 2 residents (R35) observed to have their blood glucose checked during the survey. In addition, the facility failed to ensure outside volunteers passed water to residents using a sanitary method which had potential to affect all of the residents on the second and third floors who are able to drink water. Findings include: During observation on 4/15/15, at 7:27 p.m. licensed practical nurse (LPN)-I was standing at a mobile medication cart in the hallway preparing medications for the North and South wings of the second floor. LPN-I had audible congestion, and stated she had a sore throat adding, "My whole head hurts." She had developed these symptoms, including a fever, on 4/14/15. LPN-I checked her temperature, and had a fever of 99.2 degrees Fahrenheit (F). Further, LPN-I stated she should not be working with residents as she was ill, "If I have a fever, I probably shouldn't be here." When interviewed on 4/15/15, at 7:34 a.m., registered nurse (RN)-D stated staff members are not to be working if they are ill and/or have a fever, "That's just the policy." During continued observation of LPN-I, on 4/15/15 at 7:37 a.m., she continued to prepare medication for residents, despite identifying	21390	Completed on 5/14/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 36	21390		

herself as having a fever and being ill. LPN-I did not wear any gloves or mask during the medication preparation, and stated she would notify the director of nursing (DON) or scheduler when they arrive at the facility later in the morning stating, " I will talk to them."

When interviewed on 4/15/15, at 8:12 a.m. RN-F stated a staff member who had nasal type symptoms or fever should not be working with the resident population, and should be sent home adding, "I think it's just kind of a common sense thing."

During additional observation of LPN-I on 4/15/15 at 8:41 a.m., she prepared and administered a cup of oral medications to R18. LPN-I did not have any gloves on, or face mask in place to reduce the risk of infection transmission as she passed the medications. LPN-I continued to prepare and pass medications to residents, despite being identified as having a fever and being ill, to residents until 9:30 a.m. when she gathered her belongings and left the floor.

A facility Employee Health Infection Control policy, dated 4/29/14, identified a purpose including, "To reduce the potential transmission of infectious agents to the physically or medically frail resident or to co-workers." Further, the policy identified a procedure which included, "No employee may report to work with a fever...or other contagious disease until you have been treated for 24 hours."

LACK OF PROTECTION DURING BLOOD GLUCOSE CHECK:

R35 was observation on 4/14/15, at 10:54 a.m. when licensed practical nurse (LPN)-H pierced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 37 R35's finger with a single use lancet (device which contains a needle that is used to expose blood) and squeezed R35 ' s finger with her bare hands exposing blood. LPN-H obtained a sample on the testing strip of the glucometer, and returned to the medication cart. LPN-H did not have any gloves on during R35's blood glucose check. When interviewed on 4/14/15, at 10:55 a.m. LPN-H stated she should have worn gloves to check R35's blood glucose, but wanted to let R35 get to the lunch meal, "Just hurry up and do it so she can go." During interview on 4/16/15, at 10:14 a.m. registered nurse (RN)-F stated all nurses are trained to wear gloves when performing blood glucose monitoring for residents, and LPN-H should have had gloves on when checking R35's blood glucose. A facility Blood Glucose Monitoring policy, dated 4/29/14, identified a procedure which read, "Put on non-sterile gloves" prior to obtaining a blood sample. LACK OF SANITARY WATER PASS TO RESIDENTS: During an observation of the third floor morning water pass performed on 4/15/15 by volunteers from an outside agency, revealed a lack of hand hygiene practices to reduce the risk of possible cross contamination and spread of infection to residents. On 4/15/15, at 9:27 a.m. Volunteer (VOL)-C entered resident room 355, palmed (entire palm of hand placed on top of lid to open) the lid of the water cup; VOL-C hand touched the drinking area of the lid where the resident would put lips to sip	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 38 water from cup. VOL-C carried the cup to the restroom sink, and tipped the cup upside down placing the rim of the cup on the bathroom sink, then put the lid on after touching the outside of the sink and the water faucet, then carried it out of the room and handed it to VOL-A. VOL-A palmed the lid; VOL-A again touched the drinking area on lid. VOL-A filled the cup with water via water cooler on a cart. VOL-A then replaced the lid of the cup and touched the drinking area again. VOL-C stood on the other side of VOL-A and waited for cup to be filled and was observed to touch face, hair, and water cart. VOL-C then un-wrapped a drinking straw and touched both ends. VOL-A handed VOL-C the water cup. VOL-C placed the straw in the cup and returned water to room 355. On 4/15/15, at 9:34 a.m. VOL-D entered resident room 310. VOL-D picked up the water cup by the lid and removed the straw. Once the lid was removed, VOL-D carried the cup to the restroom with her forefinger inside the cup holding onto it. VOL-D dumped the water out of the cup, touched the bottom of the cup to the drain grate in the sink, and then palmed the lid and put it back on. VOL-D then returned to the cart that was outside of the room and handed the water cup to VOL-A. VOL-A then palmed the lid; touched the drinking area. VOL-A then filled it with water and placed the lid back on; touched the drinking area of the lid. VOL-D had been standing next to the water cart touched her clothes and the water cart, then unwrapped and touched both ends of the straw. VOL-D returned the water glass to room 310. No observations were made of volunteers practicing safe hand hygiene during these observations, the water pass was ceased and staff educated on lack of sanitary practice used. All residents had clean cups exchanged for soiled cups.	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 39 During an interview on 4/15/15, at 9:36 a.m. registered nurse (RN)-F in charge of infection control stated expectations of hand hygiene during water pass and the water pass had not been performed in accordance with recommended infection control practices. RN-F stated volunteers were required to go through orientation, which included infection control. RN-F stated she did not provide orientation on infection control to volunteers. RN-F was not aware of what topics were covered under the infection control portion of orientation. RN-F stated the activities director provided orientation. During an interview on 4/15/15, at 9:39 a.m. activities director (AD)-I verified she had been in charge of the coordination of the volunteers from the outside agency and was responsible for orientation to the facility that included the infection control portion. AD-I explained, the volunteers passed water for the second and third floor residents. AD-I stated the infection control portion of orientation did cover hand hygiene. AD-I verified volunteers that were present had received orientation. AD-I stated, the volunteer's supervisor were supposed to be trained as well to provide oversight and guidance when needed. The facility's Volunteer Orientation Checklist dated 6/14/00 read, "Infection control (hand washing procedure)." A policy pertaining to hand hygiene was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure an infection control program was in place and followed by staff. The director of nursing could inservice all staff to ensure an infection control program was followed. The director of nursing could monitor staff compliance.	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 40 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21395	MN Rule 4658.0805 Persons Providing Services All persons providing services, including volunteers, with a communicable disease as listed in part 4605.7040 or with infected skin lesions must not be permitted to work in the nursing home unless it is determined that the person's condition will permit the person to work without endangering the health and safety of residents and other staff. The employee health policies required in part 4658.0800, subpart 4, item F, must address grounds for excluding persons from work and for reinstating persons to work due to a communicable disease or infected skin lesions. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff with signs and symptoms of potentially communicable disease did not provide services for residents which had potential to affect 18 of 34 residents residing on the second floor of the facility Findings include: During observation on 4/15/15, at 7:27 p.m. licensed practical nurse (LPN)-I was standing at a mobile medication cart in the hallway preparing medications for the North and South wings of the second floor. LPN-I had audible congestion, and stated she had a sore throat adding, "My whole head hurts." She had developed these symptoms, including a fever, on 4/14/15. LPN-I	21395	Completed on 5/14/15	5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21395	Continued From page 41	21395		

checked her temperature, and had a fever of 99.2 degrees Fahrenheit (F). Further, LPN-I stated she should not be working with residents as she was ill, "If I have a fever, I probably shouldn't be here."

When interviewed on 4/15/15, at 7:34 a.m., registered nurse (RN)-D stated staff members are not to be working if they are ill and/or have a fever, "That's just the policy."

During continued observation of LPN-I, on 4/15/15 at 7:37 a.m., she continued to prepare medication for residents, despite identifying herself as having a fever and being ill. LPN-I did not wear any gloves or mask during the medication preparation, and stated she would notify the director of nursing (DON) or scheduler when they arrive at the facility later in the morning stating, " I will talk to them."

When interviewed on 4/15/15, at 8:12 a.m. RN-F stated a staff member who had nasal type symptoms or fever should not be working with the resident population, and should be sent home adding, "I think it's just kind of a common sense thing."

During additional observation of LPN-I on 4/15/15 at 8:41 a.m., she prepared and administered a cup of oral medications to R18. LPN-I did not have any gloves on, or face mask in place to reduce the risk of infection transmission as she passed the medications. LPN-I continued to prepare and pass medications to residents, despite being identified as having a fever and being ill, to residents until 9:30 a.m. when she gathered her belongings and left the floor.

A facility Employee Health Infection Control

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21395	Continued From page 42 policy, dated 4/29/14, identified a purpose including, "To reduce the potential transmission of infectious agents to the physically or medically frail resident or to co-workers." Further, the policy identified a procedure which included, "No employee may report to work with a fever...or other contagious disease until you have been treated for 24 hours." SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure staff were not working when ill. The director of nursing could inservice all staff to ensure staff were not to work when ill. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21395		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must	21426		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 43 be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure screening for possible active tuberculin symptoms with tuberculin skin test (TST) had been completed for 5 of 5 residents (R21, R34, R41, R95, R97) newly admitted to the facility and failed to ensure tuberculosis testing with TST was evaluated correctly for 3 of 5 residents newly admitted to the facility and failed to ensure tuberculosis testing was completed for 2 of 5 employees (E-A and E-B) newly hired. Findings include: NEWLY ADMITTED RESIDENTS LACKED TST REQUIREMENTS: R21 had been admitted to the facility on 12/15/2014 according to the face sheet. According to the IMMUNIZATION RECORD for R21 the first step tuberculin skin test (TST) on 12/16/14 and on 12/18/14 the results were recorded as negative however, lacked millimeters (mm) of induration. The second step TST was administered on 12/28/14 and on 12/28/14 the results were recorded as negative however the measurement lacked mm of induration. R34 had been admitted to the facility on 11/25/2014 according to their face sheet. R34 was administered the first step TST on 11/25/14	21426	Facility failed to do screenings on 5 of 5 newly admitted residents. TB tests results were not documented in millimeters of induration. Facility failed to administer second Mantoux on new resident and did not give two step Mantoux on recently new employees. Facility has changed new employee process by developing a screen/immunization form that must be completed with infection control coordinator prior to direct care within the facility. New education material provided to nursing staff on proper techniques of reading and documenting results of the Mantoux test. A screening from for new residents has been developed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 44	21426		

and on 11/8/14 the results were recorded as negative and not in millimeters of induration. No evidence was located in in the medical record R34 had received the second step TST.

R41 had been admitted to the facility on 11/20/14 according to her face sheet. R41 ' s medical records was reviewed and there was no indication of having any TST test completed before or after admission. The facility was asked for TST information and none was provided.

R95 had been admitted to the facility on 11/12/14 according to the face sheet. R95 ' s medical record was reviewed and there was no indication of a TST being completed and on asking the provider for this information none was provided.

R97 had been admitted to the facility on 12/5/14 according to the face sheet. R97 ' s medical records was reviewed and no indication of TST being completed. However, on asking the facility a copy of form IMMUNIZATION RECORD was provided and it had the initial TST given on 12/5/14 and then learned that they read the TST on 12/8/14 with results of " neg [negative] " however, there was no documentation of how many mm of induration. Also there was no second TST completed.

LACK OF TST TESTING FOR NEWLY HIRED EMPLOYEES HOW HAD CONTACT WITH RESIDENTS:

E-A had been hired on 3/6/15. A form used for TB results was given to surveyors which had no title. This form had E-A name, box checked for new employee, TB test dated 3/5/14, with results of zero mm read by registered nurse on 3/6/15. There was no second TST completed for E-A.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 45 Nursing assistant (NA)-G was administered the first step PPD on 1/5/15, no results were found in the employee file. The second step PPD was administered on 1/16/15, no results were found in the employee's record. E-B had been hired on 3/10/15. The unnamed form with TB results Evidence of a second step PPD was not found in the employee's record. During an interview on 4/16/15, at approximately 1:00 p.m. the infection control registered nurse (RN)-F verified results of TST were incorrectly recorded, stated symptom screens for active tuberculosis should have been completed for residents, and stated employees and residents should have had second step TST administered. RN-F stated the facility did not have a policy pertaining to tuberculosis screening; the facility used the Centers for Disease Controls (CDC) guidelines and recommendations. SUGGESTED METHOD OF CORRECTION: The infection control coordinator could develop a method of tracking screening tests and administration and TSTs and educate staff on how to appropriately read/document TST results. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service	21530		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 46 Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the consultant pharmacist identified irregularities for psychoactive medication use and that the	21530	Completed on 5/14/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 47 physician follows up on recommendations for of 5 residents (R83) reviewed for unnecessary medications. Findings include: R83 was admitted to the facility on 5/23/2014 according to the facility's admission record. R83's facility Diseases Index Report revealed R83 was admitted to the facility with diagnoses that included but were not limited to dementia with behavioral disturbance and depressive disorder. The diagnosis of Schizophrenia with acute exacerbation was added on 5/30/14 and the diagnosis of paranoia agitation was added on 6/27/14. R83's quarterly Minimum Data Set (MDS) dated 10/29/14 indicated severe cognitive impairment and displayed behavioral symptoms not directed at others one to three days during the assessment period. The MDS revealed a staff assessed mood monitoring (PHQ-9) score of 10 indicating moderate depressive symptoms. Signed physician orders dated 4/12/15 included Risperdal (antipsychotic medication) 0.5 mg by mouth once per day for diagnoses of paranoia/agitation. The original start date was 6/23/14 and was administered twice per day; order was changed to 0.5 mg once per day in November 2014. There was no indication that the resident was not assessed for potential extrapyramidal side effects after the initiation of Risperdal June 2014 nor was there side effects assessed after the dose reduction November 2014. There was no resident specific target behaviors identified to determine if the Risperdal was affective or not. Signed physician orders dated 4/12/15 included Depakote (mood stabilizing medication) 250 mg by mouth once per day. The original start date had been 7/30/14. There was no information in regards to attempting a gradual dose tapering of	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 48	21530		

the Depakote since the medication was started on 7/30/14. There was no resident specific target behaviors identified to determine if the medication was affective or not.
Signed physician orders dated 4/12/15 included Trazodone (antidepressant medication which is used for insomnia) 50 milligrams (mg) by mouth before bed and 50 mg by mouth as needed if not asleep in one hour. The start date of Trazodone was 6/17/14. The as needed order was added on 7/23/14. The pharmacist recommended reducing the Trazodone to 25 mg 7/24/14 due to possible side effects of resident falling. The Trazodone was not reduced at this time and there was no gradual dose taper done since ordered on 6/17/14 or a physician ' s justification as to why the gradual dose tapering was contraindicated at this time.
Signed physician orders dated 4/12/15 included Zoloft 100 milligrams (mg) every day for depression. The original start date of Zoloft was pre-hospitalization. The physician had ordered Zoloft be reduced to 50 mg per day times one week in July 2014 then it returned to current dose of 100 mg per day. There was no gradual dose reduction attempted twice in the first year being on Zoloft nor was there a physician ' s justification as to why it was contraindicated to reduce the Zoloft. A pharmacist note dated 8/8/14 included "family has declined this med change" as a reason a gradual dose taper was not attempted. However, this is not an acceptable reason for not attempting a dose reduction. Also the Zoloft lacked specific resident mood and/or behaviors to monitor to determine if the Zoloft was affective. The only behavior monitoring tracking form that was evident in the medical record was from March 2015 and had been used to monitor depression. The target behaviors indicated were crying/restlessness. The interventions that were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 49 listed were generic and not resident specific. The documentation reflected 1 episode of crying and restless for the month of March. During an interview on 4/15/15 registered nurse (RN)-E verified the facility had not developed target behaviors and interventions and monitoring had not been performed. RN-E verified there were not individualized interventions for target behaviors of restlessness and crying for mood monitoring for depression. RN-E also verified there was no evidence in the medical record of any follow up with the psychologist for possible medication regimen adjustment as a result of the pharmacy recommendation on 2/13/15. A facility policy Pharmaceutical Services read, "nurses shall monitor the administered medications dose response ...nurses shall monitor for beneficial therapeutic response, adverse drug response, common side effects, lack of therapeutic response, lack of resident response." and "Monthly the nursing staff shall chart a summary of observe dose-response of the administered medications.", and "The consultant pharmacist shall monitor all aspects of medication utilization." SUGGESTED METHOD OF CORRECTION: The consultant pharmacist and director of nursing could review and revise policies and procedures to ensure medication irregularities were identified. The director of nursing could monitor conmpliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring	21540		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 50 Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on record review and interview, the facility failed to identify target behaviors for the use an antipsychotic, mood and behavior for use of psychoactive medications to determine if they were affective. Also to attempt a gradual dose reduction/taper twice within the first year of starting the medication or a physician ' s justification as to why it was contraindicated. Also lack of monitoring antipsychotic medication for side effects was not done. This was noted for 1 of 5 residents (R83) reviewed for unnecessary medications. Findings include: R83 was admitted to the facility on 5/23/2014	21540	Completed on 5/14/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 51 according to the facility's admission record. R83's facility Diseases Index Report revealed R83 was admitted to the facility with diagnoses that included but were not limited to dementia with behavioral disturbance and depressive disorder. The diagnosis of Schizophrenia with acute exacerbation was added on 5/30/14 and the diagnosis of paranoia agitation was added on 6/27/14. R83's quarterly Minimum Data Set (MDS) dated 10/29/14 indicated severe cognitive impairment and displayed behavioral symptoms not directed at others one to three days during the assessment period. The MDS revealed a staff assessed mood monitoring (PHQ-9) score of 10 indicating moderate depressive symptoms. The MDS also indicated R83 required extensive of one staff member for activities of daily living with the exception of bed mobility where R83 required assist of two staff members. Signed physician orders dated 4/12/15 included Risperdal (antipsychotic medication) 0.5 mg by mouth once per day for diagnoses of paranoia/agitation. The original start date was 6/23/14 and was administered twice per day; order was changed to 0.5 mg once per day in November 2014. There was no indication that the resident was not assessed for potential extrapyramidal side effects after the initiation of Risperdal June 2014 nor was there side effects assessed after the dose reduction November 2014. There was no resident specific target behaviors identified to determine if the Risperdal was affective or not. Signed physician orders dated 4/12/15 included Depakote (mood stabilizing medication) 250 mg by mouth once per day. The original start date had been 7/30/14. There was no information in regards to attempting a gradual dose tapering of the Depakote since the medication was started	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 52 on 7/30/14. There was no resident specific target behaviors identified to determine if the medication was affective or not. Signed physician orders dated 4/12/15 included Trazodone (antidepressant medication which is used for insomnia) 50 milligrams (mg) by mouth before bed and 50 mg by mouth as needed if not asleep in one hour. The start date of Trazodone was 6/17/14. The as needed order was added on 7/23/14. The pharmacist recommended reducing the Trazodone to 25 mg 7/24/14 due to possible side effects of resident falling. The Trazodone was not reduced at this time and there was no gradual dose taper done since ordered on 6/17/14 or a physician ' s justification as to why the gradual dose tapering was contraindicated at this time. Signed physician orders dated 4/12/15 included Zoloft 100 milligrams (mg) every day for depression. The original start date of Zoloft was pre-hospitalization. The physician had ordered Zoloft be reduced to 50 mg per day times one week in July 2014 then it returned to current dose of 100 mg per day. There was no gradual dose reduction attempted twice in the first year being on Zoloft nor was there a physician ' s justification as to why it was contraindicated to reduce the Zoloft. A pharmacist note dated 8/8/14 included "family has declined this med change" as a reason a gradual dose taper was not attempted. However, this is not an acceptable reason for not attempting a dose reduction. Also the Zoloft lacked specific resident mood and/or behaviors to monitor to determine if the Zoloft was affective. R83's care plan with a last review date of 11/13/2014 identified R83 had severe dementia, paranoid state and depression. It alerted staff R83's alertness fluctuated, had a lack of safety	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 53	21540		

awareness and was impulsive. The care plan identified target behaviors as "crying and restlessness." The care plan gave the direction, "mood and behavior monitoring sheets to be filled in by NAR's [nursing assistant registered] every shift." The care plan lacked identification of individualized interventions for Zoloft and Trazodone. The care plan lacked any individualized target behaviors or interventions for the use of Risperdal and Depakote.
The only behavior monitoring tracking form that was evident in the medical record was from March 2015 and had been used to monitor depression. The target behaviors indicated were crying/restlessness. The interventions that were listed were generic and not resident specific. The documentation reflected 1 episode of crying and restless for the month of March.
During an interview on 4/15/15 registered nurse (RN)-E verified the facility had not developed target behaviors and interventions and monitoring had not been performed. RN-E verified there were not individualized interventions for target behaviors of restlessness and crying for mood monitoring for depression.
A facility policy Pharmaceutical Services read, "nurses shall monitor the administered medications dose response ...nurses shall monitor for beneficial therapeutic response, adverse drug response, common side effects, lack of therapeutic response, lack of resident response." and "Monthly the nursing staff shall chart a summary of observe dose-response of the administered medications." and "The consultant pharmacist shall monitor all aspects of medication utilization ..." and "The nursing staff shall obtain the primary medical diagnosis indicating the reason for psychoactive medication order. The goal of the psychoactive drug therapy should be specified in the resident's history or in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 54 the physician's progress notes. This information will be listed on the pharmaceutical care plan and on behavior monitoring sheets ...the nursing staff shall define and list targeted behavior symptoms, which shall be monitored and counted for the purpose of defining psychoactive dose response ...The attending physicians shall reevaluate all psychoactive orders at least every six months. This reevaluation shall document the psychoactive dose response, therapeutic outcomes and shall attempt to determine the lowest effective control dose of the drug ..." SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure monitoring of psychoactive medications. The director of nursing could inservice all staff to monitor psychoactive medications. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure accurate labeling of medications for 3 of 6 residents (R104, R14, R57) observed to receive medication during the survey, and 1 of 5 residents (R10) reviewed for unnecessary medication use.	21620	Completed on 5/14/15	5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 55 Findings include: R104's admission Minimum Data Set (MDS), dated 4/1/15, identified R104 had intact cognition, and received a daily insulin injection. R104's Orders from Doctor fax, dated 3/31/15, identified an order of, "[change] Novolog rapid acting insulin dosing to 2 units/15 gram carb. [carbohydrates] with meals, per resident." During observation of medication administration on 4/14/15, at 11:25 a.m. licensed practical nurse (LPN)-H prepared insulin for R104 in the medication room on the second floor of the facility. The Novolog insulin vial was provided to the surveyor and read, "INJECT 1 UNIT SUBCUTANEOUSLY FOR EVERY 15 GRAMS EATEN THREE TIMES DAILY." There was no modification to the label to alert staff to refer to the updated order on 3/31/15 physician orders. LPN-H prepared the insulin according to the physician order, and administered it to R104. When interviewed on 4/14/15, at 11:28 a.m. LPN-H stated she did not read the label prior to preparing the insulin for injection, "I'll be honest with you, I did not look at that." Further, the "label is incorrect" and she would notify the pharmacy to obtain a new label in order to reduce the risk of a medication error. R14's quarterly MDS, dated 1/21/15, identified R14 was cognitively intact. R14's Discharge Medication List, dated 11/15/14, identified an order of, "OCULAR [eye] LUBRICANT (THERATEARS OPHTHALMIC SOLUTION) 1 DROPS, EYES (BOTH), FOUR TIMES A DAY." During observation of medication administration on 4/14/15, at 11:41 a.m. LPN-H prepared the	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 56 eye drops and provided the container to the surveyor which read, "INSTILL 1 DROP IN BOTH EYES FOUR TIMES DAILY AS NEEDED FOR DRY EYES." There was no modification to the label to alert staff to refer to the physician orders updated 11/15/14. When questioned regarding the label and order discrepancy, LPN-I stated the label was not accurate, and she would notify the pharmacy. Further, LPN-I stated the night shift nurse is assigned to check for correct medication labeling, however since the facility had cut staffing hours, it was becoming harder to get it completed. R57's annual MDS, dated 2/11/15, identified R57 was cognitively intact, and took a daily anti-anxiety medication. R57's Physician Orders Sheet, dated 4/7/15, identified an order of, "Ativan [anti-anxiety medication] 0.5 mg [milligrams] tab [tablet] 1/2 [one half] per PEG [Percutaneous Endoscopic Gastrostomy] tube BID [twice a day]." During observation of medication administration on 4/16/15, at 7:50 a.m. registered nurse (RN)-A prepared R57's at a mobile cart. The Ativan package was provided to the surveyor and read, "LORAZEPAM [Ativan] TAB 0.5 MG ... TAKE 1 TABLET VIA [by way of] PEG TWICE DAILY." There was no modification to the label to alert staff to refer to the physician orders dated 4/7/15 for use of half tablet of Ativan. When questioned regarding the label and order discrepancy, RN-A stated the label was inaccurate, and the facility had been faxing the pharmacy in order to get it changed for over a month, but it had not been completed yet. Further, RN-A added, "Our protocol is to get a new label." R10's Humalog medication label on the vial currently in use read, "inject 7 units	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 57 subcutaneously in the morning; inject 6 units subcutaneously at noon." The insulin had a dispense date of 4/2/15. R10 had diagnosis that included diabetes mellitus. R10's physician orders signed & dated 2/10/15, revealed orders for Humalog insulin seven (7) units at 8:00 a.m., five (5) units at 12:00 p.m., and three (3) units at 6:00 p.m. The physician order for Humalog insulin five (5) units at 12:00 p.m. had a start date of 6/28/14. The physician order for Humalog insulin three (3) units at 6:00 p.m. had a start date of 2/11/14. However, the label for Humalog should have read six (6) units at 12:00 p.m. or noon. Also the label did not include the 6:00 p.m. dose of three (3) units of Humulin insulin. Document review of the facility medication administration record for 4/1/15 through 4/14/15, revealed R10 received insulin as ordered. Document review of blood sugar reports faxed to physician dated 11/20/14, 12/3/14, 1/28/15, 2/4/15, 2/25/15, 3/4/15, and 3/25/15, each identified R10 received Humalog insulin doses as ordered. During interview on 4/16/15, at 9:30 a.m., registered nurse (RN)-E verified the insulin label dispense date of 4/2/15 and that the label directed Humalog 7 units in the morning and 6 units at noon. During interview at that time, RN-E verified the insulin label did not include three units at 6:00 p.m., as physician ordered. RN-E verified the label did not include the current physician order for five units at 12:00 p.m. RN-E stated she expected nurses to notify the pharmacy when there were label discrepancies.	21620		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21620	Continued From page 58 When interviewed on 4/16/15, at 9:24 a.m. the dispensing pharmacist (P)-A stated incorrect medication labels should be immediately reported to the pharmacy so they can be corrected, and nursing staff should place a "directions changed" sticker on the label to reduce the risk of medication error until they can be changed. A facility Pharmaceutical Services policy, dated 3/1999, identified, "Medication inventory shall be periodically inspected to insure the proper storage of an accurate, current, non-expired drug supply for each resident." Further, the policy added, "Medication change orders resulting in new directions on the container label shall necessitate a new label", and listed a procedure including, "Nurse removes the respective container of medication and crosses the existing label with a large black line or X." SUGGESTED METHOD OF CORRECTION: The director of nursing and pharmacist could review and revise policies and procedures to ensure medication labels reflected physician orders. The director of nursing could inservice licensed staff to ensure accurate medication labels. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors,	21695		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 59 ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain food service equipment in a sanitary manner for 63 out of 64 residents. This had the potential to effect 63 out of 64 residents that resided in the facility. Findings include: During the tour of the facility ' s kitchen guided by the certified dietary manager (CDM) on 4/13/15, at 3:10 p.m. The convection oven tops had a layer of gray dust, the faces or fronts of the ovens had an overall smeared with debris appearance. They had a layer of black greasy appearing substance and crumbs of dry debris on the stainless steel below the oven door. The inside bottom of the ovens showed rust areas with a thick layer of dried black debris build up. The ovens located next to the convection ovens had oven racks set on top of oven and underneath the racks the oven surfaces had dried debris and dust. The fronts of the ovens were smeared with debris in appearance. The large mixer had dried debris and dust on the legs, where the bowl connects to the mixer, and around the legs of the mixer. The area where the beater would be attached showed yellow congealed fluid. The combination grill/oven faces were soiled and had dried food debris underneath. A long preparation table that had small appliances including a microwave, a food processor, a mixer and a blender on top was cluttered and had food debris along the back edge. The microwave had small area of rust and built up of food debris on the left hand side near	21695	Completed on 5/14/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 60 the door latch. The underside of the small mixer where the beater would be attached showed a buildup of dark debris. The floors underneath the sink, the long preparation table (table with small appliances), and the dishwasher area were extremely soiled with debris. The mop boards or base boards that surrounded the kitchen were soiled with a black buildup of debris. The grouted areas of the tile floor around the baseboards showed black buildup of debris too. During a kitchen tour on 4/16/15, at 10:30 a.m. (two days later) the same findings as outlined were observed. During an interview on 4/16/15, at 11:26 a.m. CDM stated a cleaning schedule is used and expected staff to follow the schedule. CDM explained the maintenance department pressure washed the floors once a month and sometimes once a week with a floor machine. The facility cleaning schedule gave direction to staff to clean work area daily. The cleaning schedule did not give details of surface areas or equipment in the "work area" that may need daily cleaning and upkeep. SUGGESTED METHOD OF CORRECTION: The registered dietician and the housekeeping director could review and revise policies and procedures to ensure a clean and sanitary kitchen was maintained. The registered dietician could inservice dietary staff to maintain a clean and sanitary kitchen. The registered dietician could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 61	21805		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a dignified dining experience on the 3rd floor west dining room for 4 of 4 residents (R3, R83, R33 and R6) who were seated together during their dining experience. Findings include: R3, R83, R33 and R6 all dependent on staff to eat their meal were observed during observations on 4/13/15 at 5:07 p.m., on 4/14/15 at 9:05 a.m. and 4/16/15 at 11:45 p.m. located on the third floor west dining room also referred to by staff as the " feeder dining room." It was observed that the tables in this dining area did not have placemats or table center pieces and the resident ' s food was left on the serving trays while residents were assisted to eat. However, the independent dining room had fresh flowers and placemats on the tables also the resident ' s meals were delivered to the residents on serving trays and the meal was removed from the serving trays. R3 was observed on 4/13/15, at 5:11 p.m. when nursing assistant (NA)-E donned a clothing protector on R3; NA-E did not give R3 the choice	21805	Completed on 5/14/15	5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 62 if she wanted the clothing protector on and NA-E did not inform R3 the clothing protector was going to be applied. R83 was observed on 4/13/15; at 5:15 p.m. NA-E placed a meal serving tray off to the side of R83. NA-E did not uncover the meal for the resident and left the room. R83 then attempted to grab the silverware off of the tray. At 5:17 NA-E returned, uncovered the meal, cut up the sandwich, and left the dining room again. R33 was observed on 4/13/15; at 5:16 p.m. NA-E removed R33 from the table and took R33 out of the dining room per a licensed nurse request. R33's tray was placed on the table at 5:19 p.m. R33 returned to the dining room at 5:20. R6 was observed on 4/13/15, at 5:19 p.m. NA-F placed meal tray in front of R6 who was still sleeping since the start of meal service. NA-F then uncovered the food tray that contained pureed cold ham sandwich, pureed cooked carrots, and pureed mashed potatoes. Then NA-F walked away from the table. NA-F did not attempt to awake R6 until 5:27 p.m.; this attempt to arouse R6 was not successful. NA-F did not attempt to awake R6 again until 5:49 p.m. R6's food had remained uncovered for 30 minutes. NA-F did not take the temperature of the food prior to assisting R6 to eat. R6. NA-F stood next to R6 and gave bites of food items mixed together on the spoon. Throughout the majority of the 4/13/15 dinner service NA-E and NA-F were not present in the dining room at the same time; this left one NA to assist four residents at two different tables. The NA that was left in the dining room alone moved from resident to resident and table to table, gave	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 63 a few bites to all residents within minutes of each other. NAs were observed on several occasions to stand next to the resident when assisting them with eating. NAs did not wash/sanitize hands between residents after touching tables, wheelchairs, and wiping faces off. During an interview on 4/13/15, at 5:11 p.m. NA-E referred to the west dining room as the " feeder dining room. " NA-E explained residents that required assistance with eating were assigned to that dining room on admission to the facility. During an interview on 4/16/15 at 10:04 a.m. registered nurse (RN)-F stated the dining room was referred to as the " feeder dining room " , stated residents could eat in the main dining room on the first floor, stated people that are not able to communicate preference are assigned to the " feeder dining room " on admission. RN-F was not aware if the meal was supposed to be removed from the serving tray or not. RN-F explained NAs supposed to wash/sanitize hands between residents and touching surfaces that may be contaminated. RN-F stated NAs had received education pertaining to hand washing and received education routinely. During an interview on 4/16/15, at 10:21 a.m. certified dietary manager (CDM) verified the west dining room on the 3rd floor was referred to as the " feeder dining room." CDM stated, " We put the " feeders " in that dining room on admission." CDM stated, " The meals go up on trays, they should be disassembling the trays and put in front of the resident." CDM stated, " We don ' t put placemats down [in reference to 3rd floor west dining room]." Facility policy Resident with Swallowing	21805		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21805	Continued From page 64 Difficulties date last revised 4/30/14 read, " Residents who eat in the 1st floor dining room must eat independently and are not at risk for aspiration." Facility policy East Dining Room Hostess/Nurse Aide Responsibilities last reviewed 4/29/15 instructed staff to " provide residents with prompt, dignified meal service, wash hands, prevent spread of infection ...., serve all residents at a table before serving the next table ...., if a resident requires assist with eating, sit down beside him/her while assisting, arrange tray ..., never leave dining room unattended ... " SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure a dignified dining experience was provided. The director of nursing could monitor the dining room to ensure staff provided dining services in a dignified manner. The director of nursing could inservice all staff to provide a dignified dining service. The director of nursing or designee could conduct audits of the meal service and results of the audits could be reported to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as	21880		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 65 patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 66 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure unresolved grievances were acted on for 2 of 2 residents (R13, R97) reviewed who had voiced concerns with the facility staff. Findings include: R13's quarterly Minimum Data Set (MDS), dated 1/7/15, identified R13 had intact cognition. During an observation and interview on 4/13/15, at 6:16 p.m. R13 stated she had asked to be moved to a different room since she admitted to the facility, because her current room overlooked a rooftop with heating and cooling equipment. Further, R13 said, "I keep the curtains closed, because their is nothing to see." R13's curtains were closed, and secured together with a wooden clothes pin during the interview. When curtains were opened her outside view included several exhaust fans, pipes, and heating/cooling equipment was visible. When interviewed on 4/16/15, at 11:40 a.m. the licensed social worker (LSW)-A stated R13 had mentioned before that she did not like her room as their was "pipes outside the window." The interdisciplinary team had discussed moving her, but decided not to because they felt R13 likely still wouldn't be satisfied. Further, R13 had been shown one different room months ago, but declined to move. R13's Social Services Progress Note, dated 8/5/14, read, "...resident stated she would like a room with a view here at Lakeview." Further, "Res [resident] viewed a room on West wing, 3rd	21880	Completed on 5/14/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 67 floor to see if this style of room and view would please resident. Resident stated she was still looking at a roof. Resident was informed she would be considered as rooms became available." During a subsequent interview on 4/16/15, at 2:58 p.m. LSW-A stated she had not shown R13 any more rooms since 9/25/14, as R13 often naps during the day. R13 was on the waiting list for assisted living, but added, "I supposed I could show her another room." Further, LSW-A stated if a resident had a concern with their room it would be addressed "most of the time", and, "I feel she [R13] is fine in that room." A facility Grievance policy, dated 9/8/10, identified, "It is our policy to address concerns of grievances in a timely manner", and, "Within 48 hours (Monday through Friday) of receiving the concern or grievance, the resident or family member will be contacted regarding follow up." R97's quarterly Minimum Data Set (MDS) dated 3/4/15 indicated R97's ability to hear was adequate with the use of a hearing aid. R97's care plan, dated 03/15/13, read, "...Resident is able to communicate needs ...hearing is adequate with the use of bilat [bilateral] aides." In addition it directed staff to place hearing aids daily in the morning and the nurse was to check to ensure they were functioning properly and batteries were working. On 4/13/15 at 7:12 p.m. during an interview with R97 and her friend (FR)-A present, R97 was observed to not have her bilateral hearing aids in place. FR-A stated R97's bilateral hearing aids are often not in when she comes to visit her.	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 68 FR-A stated she had shared this concern with the facility staff on multiple occasions. FR-A proceeded to assist R97 with placing her hearing aids and told surveyor R97 would be able to hear the questions better now that she had her hearing aids in place. On 4/16/15 at 9:30 a.m. R97 was observed to be sitting in her recliner in her room reading the newspaper and her hearing aides had not been placed. On 4/16/15 at 9:32 a.m. licensed practical nurse (LPN)-H stated the nursing assistant who assisted R97 with morning cares was responsible for placing R97's hearing aids for the day. LPN-H stated she was unaware R97's hearing aids not being placed was a concern for R97 and FR-A. On 4/16/2015 9:38 a.m. during an observation LPN-H verified R97 did not have her hearings hearing in her ears and asked R97 if she would like to have her hearing aids placed in her ears and R97 stated "yes". LPN-H placed resident's hearing aids and R97 thanked her. On 4/16/2015 at 10:03 a.m. social services (SS)-D stated FR-A had voiced a concern to her regarding R97's hearing aids not being placed. SS-D stated she communicated this concern to the nursing department at a morning stand up meeting for follow-up to ensure R97's hearing aids were being placed daily. SS-D stated there was no further social service follow-up regarding this concern. SS-D stated her expectation was when staff was getting residents ready for the day their hearing aids should be placed. SS-D stated concerns are made into grievances right away and stated she would check her file to see if a grievance was filed regarding the concerns with	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 69 R97's hearing aids. SS-D stated a grievance should have been filed regarding the concern hearing aids not been placed. On 4/16/15 at 11:23 a.m. SS-D stated she was unable to find a grievance form regarding R97's hearing aids not being placed. SS-D stated depending on what the concerns was, determined whether or not she would initiate a concern/grievance form. SS-D stated the hearings aides would have been an issue nursing could have easily followed up on to ensure they were placed and this was why a grievance was not completed for this concern. The grievances policy and procedure dated 2010 read, " When a concern is brought to a staff member ' s attention the following steps will be taken. 1. Complete the facility's grievance form: provide as much detail as possible. 2. Immediately route the original copy to the appropriate department in the identified in the concern. Make a copy for all other departments affected by the concern (i.e. nursing, dietary, laundry, etc.). 3. Within 24 hours (Monday through Friday), the original should be returned to the Social Service office with the follow up section completed. 4. Social Services will notify the administrator of the grievance. 5. Based on the concern, the appropriate departments will meet to determine the necessary response and what department will follow up with the resident or the follow up with the resident or family member. 6. Within 48 hours (Monday through Friday) of receiving the concern or grievance, the resident or family member will be contacted regarding the follow-up. "	21880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00360	A. BUILDING: _____ B. WING _____	04/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTI	610 SUMMIT DRIVE FAIRMONT, MN 56031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21880	Continued From page 70 SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure resident and family grievances were addressed in a timely manner. The director of nursing could educate all staff on the policies and procedures. The director of nursing could monitor staff compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		