DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: IBO1

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I -	TO BE COMPI	LETED BY T	THE STAT	TE SURVEY	AGENCY		Facili	ity ID: 00360	
1. MEDICARE/MEDICAID PROVID (L1) 245280 2.STATE VENDOR OR MEDICAID (L2) 285042700		3. NAME AND AI (L3) LAKEVIEW (L4) 610 SUMMI (L5) FAIRMONT	V METHODIS T DRIVE			ГЕR 56031	4. TYPE OF 1. Initial 3. Termina 5. Validation	2 tion 4 on 6	7 (L8) 2. Recertification 3. CHOW 3. Complaint	
5. EFFECTIVE DATE CHANGE OF (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint			
6. DATE OF SURVEY 06/ 5 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	19/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR		DATE: (L35)	
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	85 (L18) 85 (L17)	Complianc1. A B. Not in Con		gram	2. Tech 3. 24 H 4. 7-Da 5. Life	nnical Personnel	7. Med	pe of Services dical Director ent Room Size	s Limit	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY M	1EETS				
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L1	5)		
85 (L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY	APPROVAL		Date:	
Wendy Buckholz, HFE N	IE II	0	06/22/2015	(L19)	a <u>mala Fiske-</u>	Downing, E	nforcement	<u>Specialist</u>	06/22/2015 (L20	
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OF	R SINGLE S	TATE AGEN	CY		
19. DETERMINATION OF ELIGIBITED AS A science of the second			IPLIANCE WITH	H CIVIL	2. 0		ncial Solvency (Ho I Interest Disclose :	,	A-1513)	
2. Facility is not Eligibl	e (L21)									
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	TION ACTION:		(L30)		
OF PARTICIPATION 06/01/1985	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Clos		05	IVOLUNTAR -Fail to Meet		
(L24)	(L41)		(L25)			on W/ Reimburse		-Fail to Meet	Agreement	
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:			04-Other Reason	untary Terminatio for Withdrawal	<u>0</u>	<u>THER</u> '-Provider Sta	tus Change	
(L27)	B. Rescind Su	uspension Date:	(L44)				00)-Active		
		•	(L45)							
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS					
		03001								
	(L28)			(L31)						
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION 06/08/2015	I OF APPROVAI	LDATE	Posted 06/3	30/2015 Co /	RePosted			
	(L32)	00/00/2015		(L33)	DETERMIN	ATION APPI	ROVAL			



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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



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, Program Specialist

Licensing and Certification Program

Division of Compliance Manitoring

Kumalu Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245280	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/19/2015
Name	e of Facility		Street Address, City, State, Zip Code	
LAKEVIEW METHODIST HEALTH CARE CENTER		610 SUMMIT DRIVE		

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
	F0166 483.10(f)(2)		Correction Completed 05/14/2015		483.15	1	Correction Completed 05/14/2015		Reg. #	F0242 483.15(b)		Correction Completed 05/14/2015
ID Prefix Reg. # LSC	483.15(h)(7)		Correction Completed 05/14/2015		483.20					F0282 483.20(k)(3)(ii		Correction Completed 05/14/2015
ID Prefix Reg. # LSC	F0313 483.25(b)		Correction Completed 05/14/2015	ID Prefix Reg. # LSC	483.25		Correction Completed 05/14/2015		Reg. #	F0315 483.25(d)		Correction Completed 05/14/2015
ID Prefix Reg. # LSC	F0322 483.25(g)(2)		Correction Completed 05/14/2015	ID Prefix Reg. # LSC	483.25	5	Correction Completed 05/14/2015		Reg. #	F0329 483.25(I)		Correction Completed 05/14/2015
ID Prefix Reg. #	F0371 483.35(i)		Correction Completed 05/14/2015	ID Prefix Reg. #	F0425	5	Correction Completed 05/14/2015		ID Prefix Reg. #	F0428 483.60(c)		Correction Completed 05/14/2015
Reviewed B		Reviewed		Date:		Signature of Sur	vevor:				Date:	
State Agen			-	06/22/20		g	-	176	7			10/001=
	Ву	GPN/k		06/22/20) Date:		Signature of Sur			<u>*</u>		Date:	19/2015

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245280	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 6/19/2015
Name	e 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
			Correction				Correction				
ID Prefix	F0441		Completed 05/14/2015	ID Prefix	E0465		Completed 05/14/2015				
					•		05/14/2015				
Reg. # LSC	483.65		=	Reg. #	483.70(h)		=				
			-	200			-	+			
		_									
Reviewed		Reviewed		Date:	Signat	ure of Su				Date:	
State Agen		GPN/ k		06/22/20				176	7	06	5/19/2015
Reviewed	Ву	Reviewed	I Ву	Date:	Signat	ure of Su	rveyor:			Date:	
CMS RO											
Followup	to Survey Co		n:		Check for	any Unco	rrected Defic	ienci	ies. Was a Summary of		
	4/16	/2015			Uncorre	ected Defic	ciencies (CM	S-25	67) Sent to the Facility?	YES	NO

State Form: Revisit Report

(Y1)	Provider / Supplier / CLIA /	(Y2) Multiple Construction	(Y3) Date of Revisit
	Identification Number	A. Building	6/19/2015
	00360	B. Wing	0/19/2013

Name of Facility

LAKEVIEW METHODIST HEALTH CARE CENTER

Street Address, City, State, Zip Code

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
		C	Correction			(Correction					Correction
			Completed				Completed					Completed
ID Prefix	20565	0	6/19/2015	ID Prefix	20570	(06/19/2015		ID Prefix	20900		06/19/2015
-	MN Rule 46	58.0405 Subr). i		MN Rule 465	8.0405 Sub	p. ₍			MN Rule 4		
LSC				LSC					LSC			
		C	orrection			(Correction					Correction
		C	Completed			(Completed					Completed
ID Prefix	20910	0	6/19/2015	ID Prefix	20930		06/19/2015		ID Prefix	20965		06/19/2015
		58.0525 Subr			MN Rule 465					MN Rule		
						·						
		C	orrection			(Correction					Correction
		C	Completed			(Completed					Completed
ID Prefix	21025	0	6/19/2015	ID Prefix	21134	(06/19/2015		ID Prefix	21390		06/19/2015
	MN Rule 46				MN RULE 46					MN Rule		
LSC				LSC					LSC			
		C	orrection			(Correction					Correction
		C	Completed			(Completed					Completed
ID Prefix	21395	0	6/19/2015	ID Prefix	21426	(06/19/2015		ID Prefix	21530		06/19/2015
-	MN Rule 46				MN St. Statu				Reg. # LSC	MN Rule	4658.1310	A.B.C
			Correction				Correction					Correction Completed
ID Prefix	21540		Completed 6/19/2015	ID Prefix	21620		Completed 06/19/2015		ID Prefix	21695		06/19/2015
Rea #	MN Rule 46	58.1315 Subr	, '	Rea #	MN Rule 465	8 1345			Rea #	MN Rule 4	1658 1415	Subn
Reviewed E	Ву	Reviewed E	Ву	Date:	Signat	ure of Surv	eyor:				Date	<u> </u>
State Agen	су	GPN/kfd		06/22/20	15		3	1767			0	6/19/2015
Reviewed E	Ву			Date:		ure of Surv					Date	
CMS RO	-		-				-					

Event ID: IBO112

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	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
		Correction			Correction				
ID Darette	01005	Completed	ID Deaf	21000	Completed				
ID Prefix		06/19/2015	ID Prefix		06/19/2015				
Reg. # LSC	MN St. Statute 144.65	1 Sul	Reg. # LSC	MN St. Statute 144.651	Sul				
LSC			LSC						
Reviewed E	By Reviewe	ed By	Date:	Signature of Sur	veyor:			Date:	
State Agend			06/22/201			767			9/2015
Reviewed E			Date:	Signature of Sur				Date:	7/2013
CMS RO	-, Iteviewe	.a by	Date.	Signature of Sur	toyor.			Date.	
	o Survey Completed	nn:							
rollowup t	, ,	JII.		Check for any Uncor Uncorrected Defice	rected Deficiencies (CM	cienci IS-256	es. Was a Summary of 57) Sent to the Facility?	VEO	NG
	4/16/2015			Onconcoled Belle	NO) COIOICO	.5 250	or, come to the racinty:	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL FE SURVEY AGENCY		ID: IBO1 Facility ID: 00360		
1. MEDICARE/MEDICAID PROVID (L1) 245280 2.STATE VENDOR OR MEDICAID (L2) 285042700	NO.	(L4) 610 SUMMI (L5) FAIRMONT	METHODIS T DRIVE , MN	T HEALT	H CARE CENTER (L6) 56031	4. TYPE O 1. Initial 3. Termin 5. Validat 7. On-Site	tion 6. Complaint		
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint			
6. DATE OF SURVEY 04/1 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	6/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE		AR ENDING DATE: (L35)		
11LTC PERIOD OF CERTIFICATIO From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	85 (L18) 85 (L17)	Compliance1. Ac X B. Not in Com	nce With equirements e Based On: cceptable POC	gram	And/Or Approved Waivers Of 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code * Code: B*		Requirements: ope of Services Limit edical Director tient Room Size eds/Room		
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS			_	
18 SNF 18/19 SNF 85	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L	.15)		
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION I	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:	_	
Gail Sorensen, F	IFE NE II	0	5/19/2015	(L19)	K <u>amala Fiske-Downing</u> ,	Enforcement	nt Specialist 06/03/2015 (L2	20	
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE S	STATE AGE	NCY		
DETERMINATION OF ELIGIBI 1. Facility is Eligible to 2. Facility is not Eligible	Participate		PLIANCE WITH	ł CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Above	ol Interest Disclo	HCFA-2572) sure Stmt (HCFA-1513)		
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	LTC AGREEM	MENT	26. TERMINATION ACTION	·:	(L30)		
OF PARTICIPATION 06/01/1985	BEGINNING	DATE	ENDING DAT	ГЕ	VOLUNTARY 00 01-Merger, Closure	_	NVOLUNTARY 05-Fail to Meet Health/Safety		
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	sement 0	06-Fail to Meet Agreement		
25. LTC EXTENSION DATE: (L27)		VE SANCTIONS n of Admissions: uspension Date:	(L44) (L45)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	<u>c</u> 0	OTHER 17-Provider Status Change 10-Active		
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS			_	
		03001			. .				
	(L28)			(L31)					
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE					

(L33)

DETERMINATION APPROVAL

(L32)



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:

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

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

<u>Remedies</u> - 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;

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

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

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

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

Lakeview Methodist Health Care Center May 4, 2015 Page 4

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

Lakeview Methodist Health Care Center May 4, 2015 Page 5

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, Program Specialist Licensing and Certification Program

Division of Compliance Monitoring

Kumalu Fishe Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 06/02/2015 FORM APPROVED OMB NO. 0938-0391

-	MENT OF DEFICIENCIES AN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION ()	(X3) DATE SURVEY COMPLETED	
		245280	B. WING		04/16/2015	
	PROVIDER OR SUPPLIER	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 610 SUMMIT DRIVE FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 000	INITIAL COMMENT	rs .	F 00			
	as your allegation of Department's acception enrolled in ePOC, year the bottom of the form. Your electron be used as verificate	·				
F 166 SS=D	on-site revisit of you validate that substate regulations has been your verification. 483.10(f)(2) RIGHT	receipt of an acceptable electronic POC, and receipt of your facility may be conducted to ate that substantial compliance with the ations has been attained in accordance with verification. 0(f)(2) RIGHT TO PROMPT EFFORTS TO DLVE GRIEVANCES		6	5/14/15	
	facility to resolve gr	ight to prompt efforts by the ievances the resident may se with respect to the behavior				
	by: Based on observate review, the facility for grievances were act (R13, R97) reviewe with the facility staff. Findings include: R13's quarterly Min 1/7/15, identified R12.	ion, interview, and document ailed to ensure unresolved ted on for 2 of 2 residents d who had voiced concerns i. imum Data Set (MDS), dated 13 had intact cognition. ion and interview on 4/13/15, ated she had asked to be		Resident R 13 has an extensive hist stealing belongings from residents at the facility. Currently she resides in troom next to the floor supervisor is of for monitoring purposes. Previously been offered other rooms throughout facility but has declined. On 5/5/15 services approached R 13 and offeres show her other rooms in the facility the she may wish to move to, in which she initially declined, and after encourage she agreed to look at the lakeside vicrooms. She declined to make any	nd che office has the cocial ed to nat ne ement	
ABORATORY	/ DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE	TITLE	(X6) DATE	

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

Electronically Signed

05/13/2015

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

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		SURVEY PLETED
		245280	B. WING			04/1	16/2015
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	. 0, 2010
LAKEVIE	EW METHODIST HEA	ALTH CARE CENTER			10 SUMMIT DRIVE AIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	moved to a differe the facility, because a rooftop with hear Further, R13 said, because their is not were closed, and so clothes pin during were opened her dexhaust fans, pipe equipment was visually with the control of the control	nt room since she admitted to se her current room overlooked ting and cooling equipment. "I keep the curtains closed, othing to see." R13's curtains secured together with a wooden the interview. When curtains outside view included several is, and heating/cooling	F 1	66	decisions at this time, and stated stand has made her decision. Social service will follow up weekly with R R 13 to see if she is ready to make decision and document accordingly Resident R97 did not have hearing place at time of survey. R 97 prefekeep her own hearing aids in her roand staff is to place them with morroares. Signs have been placed in resident is room, education in floor communication book, and placemed MAR to be checked and signed off education was done by Director of Nursing on 4/17/15. Going forward hearing aid placement will be a designated task within our Point Cli Care, EMR system. This will allow alert to make sure the hearing aids placed. Staff was educated per our facility grievance policy (SS065) to fill out grievance policy form and turn into services for timely follow up of grievand new forms were made available effective 5/14/15. Policy and proce for grievance updated stating that Grievances will be reviewed at mor stand-up meeting with IDT and follow and education provided with involve staff. Audits will be performed by so service for residents who have filed grievance monthly. Social service follow up with R 13 and R97 weekly assure no further issues have arise Director of Nursing provided reeduce material to all staff, effective date of correction 5/14/15.	ready esident a r. aids in rs to com ning nt on this the ck for an are the social rance e dure ning ow up ed ocial l a will r to en cation	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		(X3) DATE SURVEY COMPLETED		
		245280	B. WING			04/	16/2015
	PROVIDER OR SUPPLIER	LTH CARE CENTER		610	REET ADDRESS, CITY, STATE, ZIP CODE SUMMIT DRIVE IRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 166	identified, "It is our grievances in a time hours (Monday throconcern or grievance member will be con R97's quarterly Min 3/4/15 indicated R9 adequate with the undequate with the undeq	policy, dated 9/8/10, policy to address concerns of ely manner", and, "Within 48 tugh Friday) of receiving the ce, the resident or family tacted regarding follow up." imum Data Set (MDS) dated 7's ability to hear was use of a hearing aid.	F1	66			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245280	B. WING	· · · · · · · · · · · · · · · · · · ·	04	/16/2015	
	PROVIDER OR SUPPLIER W METHODIST HEA	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, 2 610 SUMMIT DRIVE FAIRMONT, MN 56031	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 166	assisted R97 with r for placing R97's he stated she was unabeing placed was a On 4/16/2015 9:38 LPN-H verified R97 hearing in her ears like to have her hea and R97 stated "ye hearing aids and R On 4/16/2015 at 10 (SS)-D stated FR-A regarding R97's he SS-D stated she cot the nursing departr meeting for follow-laids were being plawas no further soci this concern. SS-D when staff was get their hearing aids sconcerns are made and stated she woo grievance was filed R97's hearing aids should have been fhearing aids not be depending on what whether or not she concern/grievance hearings aides woo could have easily for the staff was get the staff was get the staff was get their hearing aids not be depending on what whether or not she concern/grievance hearings aides woo could have easily for the staff was given as the staff was get the s	morning cares was responsible earing aids for the day. LPN-H aware R97's hearing aids not a concern for R97 and FR-A. a.m. during an observation of did not have her hearings and asked R97 if she would aring aids placed in her ears es". LPN-H placed resident's 97 thanked her. 2:03 a.m. social services of had voiced a concern to her aring aids not being placed. It is concern to ment at a morning stand up up to ensure R97's hearing aced daily. SS-D stated there all service follow-up regarding stated her expectation was atting residents ready for the day should be placed. SS-D stated the into grievances right away all check her file to see if a laregarding the concerns with the SS-D stated a grievance filed regarding the concerns with the siled regarding the concerns was evance form regarding R97's being placed. SS-D stated the concerns was, determined	F 1	66			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY IPLETED
		245280	B. WING _		04/	16/2015
	PROVIDER OR SUPPLIER	TH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 610 SUMMIT DRIVE FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 166 F 241 SS=E	read, "When a cormember's attention taken. 1. Complete the fact as much detail as possible. Immediately rout appropriate departments. Within 24 hours (original should be reoffice with the follow 4. Social Services with grievance. 5. Based on the cordepartments will meresponse and what the resident or the family member. 6. Within 48 hours (oreceiving the conceor family member with the follow-up." 483.15(a) DIGNITY INDIVIDUALITY The facility must promanner and in an eenhances each resident or the second or the family member with the second or family me	is concern. cy and procedure dated 2010 ncern is brought to a staff in the following steps will be dility's grievance form: provide	F 16			5/14/15
	This REQUIREMEN	NT is not met as evidenced				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245280	B. WING			04/-	16/2015
	PROVIDER OR SUPPLIER EW METHODIST HEA	ALTH CARE CENTER		610	REET ADDRESS, CITY, STATE, ZIP CODE 0 SUMMIT DRIVE NIRMONT, MN 56031		
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F 241	Based on observareview, the facility dining experience room for 4 of 4 res who were seated the experience. Findings include: R3, R83, R33 and eat their meal were on 4/13/15 at 5:07 and 4/16/15 at 11:16 floor west dining the "feeder dining the tables in this diplacemats or table is food was left or residents were assindependent dining placemats on the time meals were delive trays and the meal trays. R3 was observed nursing assistant (protector on R3; Nif she wanted the odid not inform R3 to be applied. R83 was observed placed a meal sem NA-E did not uncound left the room. silverware off of the	ation, interview and record failed to provide a dignified on the 3rd floor west dining idents (R3, R83, R33 and R6) ogether during their dining R6 all dependent on staff to e observed during observations p.m., on 4/14/15 at 9:05 a.m. 45 p.m. located on the third om also referred to by staff as groom." It was observed that ining area did not have center pieces and the resident the serving trays while sisted to eat. However, the groom had fresh flowers and tables also the resident 's red to the residents on serving I was removed from the serving was removed from the serving to 4/13/15, at 5:11 p.m. when NA)-E donned a clothing A-E did not give R3 the choice clothing protector on and NA-E the clothing protector was going I on 4/13/15; at 5:15 p.m. NA-E ving tray off to the side of R83. ver the meal for the resident R83 then attempted to grab the e tray. At 5:17 NA-E returned, al, cut up the sandwich, and left	F 2	241	Facility failed to provide a dignified experience on the 3rd floor west dir room for 4 of 4 Residents (R3, R83 and R6). Facility integrated the four residents into the 3rd floor dining rowith general population so all staff present to assist residents with me 4/28/15. All staff were reeducated dietary director on 4/28/15 in regard removing the plates from the servir trays, and offering clothing protected all residents. Dietary manager reeducated on timely assistance with meals, proper hand washing between residents during but not limited to not times, and facility policy regarding of room experience. Facility has initially experience. Certified Nurse Aid will dining room daily. Nursing supervisa appoint one person daily to perform dining room audits on dining experience will be turned into QA committed. Director of Nursing has provided reeducation material to all staff, effect date of correction 5/14/15.	ning I, R33 Ir	

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	PROVIDER OR SUPPLIER W METHODIST HEA	LTH CARE CENTER		610	EET ADDRESS, CITY, STATE, ZIP CODE SUMMIT DRIVE RMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	removed R33 from the dining room per R33's tray was place R33 returned to the R6 was observed or placed meal tray in sleeping since the sthen uncovered the pureed cold ham so carrots, and pureed NA-F walked away attempt to awake F to arouse R6 was rattempt to awake F food had remained NA-F did not take to prior to assisting R to R6 and gave bits together on the spoot Throughout the maservice NA-E and Nathat was left in from resident to resafew bites to all reother. NAs were obto stand next to the with eating. NAs did	on 4/13/15; at 5:16 p.m. NA-E the table and took R33 out of r a licensed nurse request. Sed on the table at 5:19 p.m. edining room at 5:20. on 4/13/15, at 5:19 p.m. NA-F front of R6 who was still start of meal service. NA-F food tray that contained andwich, pureed cooked mashed potatoes. Then from the table. NA-F did not R6 until 5:27 p.m.; this attempt not successful. NA-F did not R6 again until 5:49 p.m. R6's uncovered for 30 minutes. The temperature of the food 6 to eat. R6. NA-F stood next es of food items mixed foon. Igority of the 4/13/15 dinner NA-F were not present in the same time; this left one NA to sat two different tables. The the dining room alone moved sident and table to table, gave sidents within minutes of each pserved on several occasions of resident when assisting them do not wash/sanitize hands after touching tables,	F2	241			
	referred to the wes	on 4/13/15, at 5:11 p.m. NA-E t dining room as the "feeder-E explained residents that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245280	B. WING		04	/16/2015
	ROVIDER OR SUPPLIER W METHODIST HEA	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 610 SUMMIT DRIVE FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
	that dining room on During an interview registered nurse (F was referred to as stated residents co on the first floor, stated residents coon the first floor, stated residents room not aware if the meremoved from the sexplained NAs supbetween residents may be contaminat received education and received education and received education and received education and received room on the the "feeder dining put the "feeders" admission." CDM trays, they should but in front of the redon 't put placema floor west dining room Facility policy Residents who eat must eat independent aspiration."	e with eating were assigned to a admission to the facility. on 4/16/15 at 10:04 a.m. (N)-F stated the dining room the "feeder dining room ", uld eat in the main dining room ated people that are not able to brence are assigned to the " " on admission. RN-F was all was supposed to be serving tray or not. RN-F posed to wash/sanitize hands and touching surfaces that ed. RN-F stated NAs had pertaining to hand washing ation routinely. on 4/16/15, at 10:21 a.m. nager (CDM) verified the west 3rd floor was referred to as room." CDM stated, "We in that dining room on stated, "The meals go up on be disassembling the trays and exident." CDM stated, "We ats down [in reference to 3rd]	F 24			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245280	B. WING		04/	16/2015
	PROVIDER OR SUPPLIER	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 610 SUMMIT DRIVE FAIRMONT, MN 56031	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 241 F 242	at a table before se resident requires a beside him/her whi never leave dining	age 8 Infection, serve all residents Infection, serve all residents Infection, if a Infection serving the next table, if a Infection serving the serving the serving arrange tray, Infection serving the serving t	F 2			5/14/15
SS=D	MAKE CHOICES The resident has the schedules, and her interests, assessinteract with membinside and outside	ne right to choose activities, alth care consistent with his or assments, and plans of care; ers of the community both the facility; and make choices s or her life in the facility that				
	by: Based on observareview, the facility of preference for wake respected for 2 of 3 reviewed for choice. Findings include: R62's quarterly Mir 3/4/15, identified by heart failure, depreand required extentransfers, dressing toileting. R62's brie (BIMS) score of nir cognitive impairme. R62 was interviewed.	imum Data Set (MDS) dated at not limited to diagnoses of ssion and diabetes mellitus sive assist of one staff for personal hygiene and ef interview for mental status the indicated moderate		Resident R 62 was intervisurveyor and indicated that sleep in to 0800, at the tim was 0700. Social services resident on 4/17/15. R 62 he liked to get up between to allow him to visit with his the breakfast table. When asked by social services we surveyor 0800 compared to stated Sometimes I just lik social services asked if he change and R 62 said I wookeep things the way they at R 21 was interviewed on 4 requested no changes at the Stating "I never know wher up".	t he liked to e of interview it re-interviewed indicated that 0700 and 0715 stable mates at R 62 was thy he told the o his 0700 he e to complain, would like any ould like to just ire. /17/15 and his time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245280	B. WING			04/	16/2015
	PROVIDER OR SUPPLIER W METHODIST HEA	LTH CARE CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SUMMIT DRIVE FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242	they [staff] come ar ready to get me up. a.m." R62's nursing admi 1/13/11 read, "lik R62's nursing assis indicated his prefer However, the staff of than 6:56 a.m. R62 was observed dressed for the day On 04/15/2015 at 7 (NR)-D stated she gand 6:40 a.m. NR-D between 6:30 a.m. when residents are what time they wou morning. NR-D state preference as for a the morning. NR-D preferred time to get this preference and assistant care guide On 4/16/2015 at 10 (SS)-A stated nursi upon admission for resident would like stated staff should morning as he prefeup and dressed already and dressed already and dressed already and staff should morning as he prefeup and dressed already and staff should should should should should should should should sh	ng?" R62 responded, "No, and get me up when they are a would like to sleep in till 8:00 dission progress note dated es to arise at 8AM" Stant undated care guide ence to, "arise [at] 8AM." was getting R62 up earlier on 4/15/15 at 6:56 a.m. to be a sitting in his wheelchair. C:14 a.m. nursing assistant got R62 up between 6:30 a.m. Distated he gets up anywhere and 7:30 a.m. NR-D stated admitted they are asked up lid like to get up in the ted R62 had not made a time he would like to get up in was unaware of R62 's et up at 8:00 a.m. even though time was indicated on nursing	F 2	242	Residents were reminded of resider rights at resident council on April 1' their ability to express their prefere. We talked specifically about wake times and HS times. Social services will weekly review preferences on morning routine for R 62 and R 21 will continue to be interviewed weekly by social service resident states that their routine is acceptable. Resident rights are resident services at resident councare asked about any concerns to a that preferences continue to be acceptable. Residents will be cont to be asked if their are any concern quarterly care conferences to assure sidents are reviewed. Director of Nursing has provided reeducation material to all staff, eff date of correction 5/14/15.	7th and nces. up R21. es until viewed cil and ssure inued ns at re all	
	at 8:00 a.m.	5 day PPS (prospective					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		245280	B. WING			04/	16/2015		
	PROVIDER OR SUPPLIER EW METHODIST HEA	LTH CARE CENTER		610	EET ADDRESS, CITY, STATE, ZIP CODE SUMMIT DRIVE RMONT, MN 56031				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 242	payment system) MR21 had moderate During interview on stated she did not regets up in the morn staff." R21 stated sheen asked about, "Because I know I I added, "We don't a regarding their more choices. During observation at 6:48 a.m. R21 we door open. R21 he "Must be time to ge surveyor walked by was waiting to get uturned her call light [staff] will probably Nursing assistant (light at 7:00 a.m. (1 her begin to get up) When interviewed stated he was await up early so she is reference are multiple resident choices ar During interview on registered nurse (Repreferences and chadmission, but R21 completed upon resident choices are stated and resident choices are stated and resident choices are suppleted upon resident choices are stated and resident choices are suppleted upon resident choices.	MDS, dated 1/18/15, identified cognitive impairment. 4/13/15, at 6:42 p.m. R21 receive a choice in when she sing, "You have to wait for she was unsure if she had ever or told staff her wishes, have to wait." Further, R21 lways just get what we want rining routine preferences and of morning cares on 4/15/15, as laying in her bed with her ollered out into the hallway, et up pretty damn soon" as the pand ready for the day, and on at 6:50 a.m. adding, "They say you have to wait you turn." NA)-B answered R21's call 0 minutes later) and helped for the day. On 4/15/15, at 7:09 a.m. NA-B re R12 had a preference to be ready for breakfast, however residents to help in the facility. Red it was important to honor	F 2	42					

AND DIAM OF CODDECTION CONTRACTOR NUMBER		IPLE CONSTRUCTION IG			E SURVEY PLETED		
		245280	B. WING			04/	16/2015
	PROVIDER OR SUPPLIER	TH CARE CENTER		STREET ADDRESS, CITY, 610 SUMMIT DRIVE FAIRMONT, MN 5603			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD NCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 242 F 258 SS=D	identified, "You [residentified, schedules choices about aspet that is significant to 483.15(h)(7) MAINT COMFORTABLE Schedules activities and significant to 483.15(h)(7) MAINT COMFORTABLE Schedules activities activities, schedules activities activities, schedules activities activities, schedules activities, schedules activities activities, schedules activities, schedules activities	Residents' Bill of Rights ident] have the right to choose is and health careand make cts of your life in the facility you." TENANCE OF OUND LEVELS	F 2				5/14/15
	by: Based on interview facility failed to ensign environment for 1 or complained about how course of the survey. Findings include: R12's quarterly Min 1/28/15, identified Finot wear hearing air hearing with "no difficult social interaction, list. During interview on stated she was both and staff often chatt. When interviewed or nursing assistant (Normplained about the staff of the chatter).	IT is not met as evidenced If, and document review, the are a quiet and comfortable of 1 residents (R12) whom had allway noise during the sy. Imum Data Set (MDS), dated at 2 was cognitively intact, did des, and had "adequate" iculty in normal conversation, stening to TV (television)." If 14/15, at 8:59 a.m. R12 hered by loud hallway noise ting outside her door. In 4/16/15, at 1:04 p.m. IA)-C stated R12 had he loud hallway noise before, aff] were gabbing and		noise bothering he chatting outside he currently resides nurses station. the communication be mindful of noise hearing of concesupervisor. Resistant services or remember having Again on 5/6/15 respectively by social services hallway being noise occasionally get offered R12 a rooffurther away from which she declines Social services estaff if she feels the disturbing to her.	ained of loud hallwher, and staff often her door. Residen near main elevato An update was plon book regarding se level immediate rn by evening nursident interviewed by a concern of nois resident was intervising in regards to the isy. R12 stated do noisy, social services in the nurses statied a move of any leducated R12 to interviewed	or and laced in staff to ely after se by not se. viewed be ion, in kind. form	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245280	B. WING		04/	16/2015	
	PROVIDER OR SUPPLIER	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 610 SUMMIT DRIVE FAIRMONT, MN 56031	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 280 SS=D	laughing." Further, did not like it, and the loud hallway noises the nurses or administration of any concerns for noise, but that NA sconcerns promptly Communication Bo and updates about Registered Nurse (Communication Bo and was unable to regarding the concerns promptly the concerns promptly Communication Bo and was unable to regarding the concerns the concerns promptly Communication Bo and was unable to regarding the concerns the concerns the concerns the concerns the could and bring it to social did not have a form and/or reduction. 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or other incapacitated under participate in plannic changes in care and A comprehensive contents.	R12 had stated before she nat any concerns about the should have been reported to nistration. 4/16/15, at 1:07 p.m. licensed N)-G stated she was unaware R12 concerning loud hallway staff should be reporting the so it can be addressed in the ok (used to relay messages resident care to staff). RN)-A reviewed the ok on 4/16/15, at 1:12 p.m. ocate any communication erns of loud hallway noise for was "nothing about noise." 4/16/15, at 2:43 p.m. RN-F ware of any concerns oise for R12, but if R12 had a complete a grievance form al services. Further, the facility al policy on noise levels 0(k)(2) RIGHT TO NNING CARE-REVISE CP eright, unless adjudged erwise found to be the laws of the State, to ng care and treatment or	F 258	on resident floors. Audits will be preformed weekly until accepted be committee. Staff was educated per our facility grievance policy (SS065) to fill out grievance policy form and turn into services for timely follow up. Polici procedure for grievance updated so that Grievances will be reviewed a morning stand-up meeting with IDT follow up and education provided winvolved staff. Director of Nursing provided reeducation material to a effective date of correction 5/14/15	the social y and tating t T and with	5/14/15	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245280	B. WING		·····	04/1	16/2015
	PROVIDER OR SUPPLIER W METHODIST HEA	ALTH CARE CENTER		61	REET ADDRESS, CITY, STATE, ZIP CODE O SUMMIT DRIVE AIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	interdisciplinary tea physician, a registe for the resident, ar disciplines as dete and, to the extent the resident, the re legal representative	am, that includes the attending ered nurse with responsibility and other appropriate staff in rmined by the resident's needs, practicable, the participation of esident's family or the resident's e; and periodically reviewed eam of qualified persons after	F 2	280			
	by: Based on intervier facility failed to reversidents (R41) who continence over the Findings include: R41 was admitted according to the fadiagnoses that incongestive heart famalaise, fatigue, a R41's admission M11/26/14 indicated Brief Interview for 15 and R41 require one staff member R41 was occasion received a diuretic R41's medication a included Lasix (diu (mg) by mouth twice R41's care plan in R41 was at risk for related to decrease	administration record (MAR) retic medication) 40 milligrams			R 41 showed a decline in continent care plan was not updated. R 41 has history of choosing to urinate in her and then call for assistance rather to using the toilet. On 4/16/17 care plaimmediately updated by case mana Previous case manager is no longe facility; new case manager was edu on 4/16/15 in regards to updating caplans in to assure accuracy for all a of care. All resident with care conferhave had care plans reviewed since 4/16/15. We will continue to monito care plans. All residents will continue be monitored quarterly and as need regards to bowel and bladder function assessment. Assistant director of no will audit care plans quarterly and a needed to insure accuracy of care presidents function. Facility is installing new electronic medical records system where nurses can chart and change care plan; changes will be immediated available for all staff. Director of Nurselector of all staff. Director of Nurselector in the care plan; changes will be immediated available for all staff. Director of Nurselector in the care plan; changes will be immediated available for all staff. Director of Nurselector in the care plan; changes will be immediated available for all staff. Director of Nurselector in the care plan is taff. Director of Nurselector in the care plan is taff.	as a pad han an was ger. r in the cated are spects rences e or all leed in on and ursing s blan ng a tem e the tely	

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	PROVIDER OR SUPPLIER EW METHODIST HEA	LTH CARE CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SUMMIT DRIVE FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	incontinence. The continence and do and read, "Residen occasionallyhas for urinary tract inferidentify the amount toileting. R41's significant chindicated R41 requistaff member for to toileting program, wurine, and used a district the facility plan to reflect the inthat had been code MDS. A communication the Physician Orders for to refuse to get up with family. States as the gets up. Reside then put call light on The physician responsible to required extensive toileting, was alway have a trial toileting medication. Again the facility did reflect the increase had been coded on care plan did not reintentional urinary in becoming short of the During an interview registered nurse (Resident).	care plan identified history of ecreased awareness to void to is incontinent of urine uterine prolapse and is at risk ection." The care plan failed to of assistance R41 required for ange MDS dated 12/31/14 ared extensive assist of one illeting, did not have a trial vas frequently incontinent of iuretic medication. If you do not update R41's care increase in urinary incontinence do not he significant change and was written on the facility's form read, "Resident continues out of bed for meals and visits she gets short of breath when ent will also void in her pad in to be changed immediately." In onded by ordering a trial of to "calm her down." So dated 3/25/15 indicated R41 assist of one staff member for incontinent of urine, did not program, and used a diuretic did not update the care plan to in urinary incontinence that the quarterly MDS and the flect R41's pattern of incontinence to avoid oreath during toileting. On 4/16/2015, at 2:36 p.m. N)-E verified care plan had or R41 after decline in	F 2	280	and infection control provided reedul material for staff, effective date of correction 5/14/15.	ucation	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245280	B. WING			04/-	16/2015
NAME OF PROVIDER OR SUPPLIER LAKEVIEW METHODIST HEALTH CARE CENTER				6	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SUMMIT DRIVE AIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280 F 282 SS=D	asked for and not p	aining to the care plan was provided. RVICES BY QUALIFIED		280 282			5/14/15
	must be provided by	led or arranged by the facility y qualified persons in Ich resident's written plan of					
	by: Based on observate review, the facility factories, the facility factories and for 1 of dependent of staff to the findings Include: R97's quarterly Min 3/4/15 indicated R9 adequate with the underly adequate with the underly state and factories and fac	ion, interview and document ailed to ensure the care plan of 1 resident (R97), who was to place hearing aids for use. imum Data Set (MDS) dated 17's ability to hear was use of a hearing aid. Ited 03/15/13, read, to communicate needs ate with the use of bilat in addition it directed staff to daily in the morning and the into ensure they were of and batteries were chargeding aids were working. p.m. during an interview with (FR)-A present, R97 was we her bilateral hearing aids in R97's bilateral hearing aids en she comes to visit her.			R 97 was found to not have hearing in place upon survey. R 97 prefers keep her own hearing aids in her roand staff is to place them with morroares with nurse to check to make they are placed and functioning prosigns have been placed in resident private room per resident and family request, education in floor community 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 floor to assure all residents with head devices were in place and found no concerns from other residents. Aud be performed on residents with head devices to ensure they are available placed, this will be done bi weekly upractice accepted by QA committee Going forward the hearing aid place will be a designated task within our Click Care, EMR system. This will for an alert to make sure the hearing	to from hing sure perly. s y's hication ng R 97's aring dits will be and limited by the point allow	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245280	B. WING		04/	16/2015
	PROVIDER OR SUPPLIER	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 610 SUMMIT DRIVE FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINDERICAL DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	FR-A said she visits On 4/16/15 at 9:30 sitting in her recline newspaper and aga been placed. On 4/16/15 at 9:32 (LPN)-H stated the assisted R97 with n for placing R97's he On 4/16/2015 9:38 LPN-H verified R97 located in her ears she would like to ha	ge 16 s frequently during the week. a.m. R97 was observed to be r in her room reading the ain her hearing aids had not a.m. licensed practical nurse nursing assistant who norning cares was responsible earing aids for the day. a.m. during an observation of did not have her hearing aids and then LPN-H asked R97 if ave her hearing aids placed in tated, "Yes." LPN-H	F 28	are placed. New case manager we ducated on 4/17/15 in regards to updating care plans to assure accifor all aspects of care. Director of provided reeducation material for effective date of correction 5/14/19	uracy Nursing all staff,	
F 313 SS=D	ear and R97 thanks On 4/16/2015 at 10 (SS)-D stated her elements are getting resident hearing aids should A care plan policy with provided. 483.25(b) TREATM HEARING/VISION To ensure that resident and assistive device the aring abilities, the assist the resident in by arranging for transfice of a practition treatment of vision	:03 a.m. social services expectation was when staff ts ready for the day their	F 31:	3		5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245280	B. WING _		04/	16/2015	
	PROVIDER OR SUPPLIER W METHODIST HEA	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 610 SUMMIT DRIVE FAIRMONT, MN 56031	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 313	This REQUIREME by: Based on observareview, the facility of (R97), who was dehearing aids, was passure hearing deventing assure hearing as adequate with the R97's care plan, da "Resident is ablehearing is adequate with the assure hearing as adequate with a compact of the place hearing aid nurse was to check functioning propertion of A/13/15 at 7:12 R97 and her friend observed to not haplace. FR-A stated are often not in where the place is the place of th	or hearing assistive devices. NT is not met as evidenced tion, interview and document failed to assure 1 of 1 resident pendent of staff to place provided daily assistance to vices were in place. Inimum Data Set (MDS) dated 27's ability to hear was use of a hearing aid. Ated 03/15/13, read, to communicate needs ate with the use of bilat communicate needs ate with the use of bilat communicate needs at the total communicate and the company to the compa	F 31	R 97 was found to not have in place upon survey. R 97 keep her own hearing aids and staff is to place them cares with nurse to check they are placed and functions in signs have been placed in private room per resident arequest, education in floor book, and placement on the checked and signed off, the was done by Director of N 4/17/15. Assistant Director preformed immediate interfloor to assure all residents devices were in place and concerns from other residence be performed on residents devices to ensure they are placed, this will be done be practice accepted by QA concerns from accepted by QA concerns from accepted by QA concerns from the residence accepted by QA concerns from the placed. The placed is a designated task we click Care, EMR system. For an alert to make sure the are placed. New case many educated on 4/17/15 in requipating care plans to assign for all aspects of care. Directive date of corrections are placed in material effective date of corrections.	r prefers to a in her room with morning to make sure oning properly. I resident a sand family's communication MAR to be a seducation ursing on a for foursing on a four of nursing found no sents. Audits will a wailable and weekly until ommittee. aid placement within our Point This will allow the hearing aids to sure accuracy sector of Nursing erial for all staff,		
	·	a m. R97 was observed to be					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		245280	B. WING		04/	16/2015
	PROVIDER OR SUPPLIER	TH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 610 SUMMIT DRIVE FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 313	sitting in her recline newspaper and agabeen placed. On 4/16/15 at 9:32 (LPN)-H stated the assisted R97 with n for placing R97's he stated she was unabeing placed on a cR97 and FR-A. On 4/16/2015 9:38 LPN-H verified R97 in her ears and ask have her hearing ai stated, "Yes" LPN-laids and R97 thank On 4/16/2015 at 10 (SS)-D stated FR-A regarding R97's he SS-D stated she cothe nursing departmenting for follow-Laids were being plaexpectation was with stated and stated she cothe nursing departmenting for follow-Laids were being plaexpectation was with stated she cothe nursing departmenting for follow-Laids were being plaexpectation was with stated she cothe nursing departmenting for follow-Laids were being plaexpectation was with stated she cotherwise she cotherw	a.m. licensed practical nurse nursing assistant who norning cares was responsible earing aids for the day. LPN-H ware R97's hearing aids not laily basis was a concern for a.m. during an observation did not have her hearing aids ed R97 if she would like to ds placed in her ears and R97 H then placed R97's hearing	F 31	3		
F 314 SS=G	residents and was r 483.25(c) TREATM	ENT/SVCS TO	F 31	4		5/14/15
	resident, the facility	rehensive assessment of a must ensure that a resident ity without pressure sores				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245280	B. WING _		04/	16/2015
	NAME OF PROVIDER OR SUPPLIER LAKEVIEW METHODIST HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 610 SUMMIT DRIVE FAIRMONT, MN 56031	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	does not develop prindividual's clinical they were unavoidade pressure sores recessivices to promot prevent new sores	oressure sores unless the condition demonstrates that able; and a resident having eives necessary treatment and e healing, prevent infection and	F 31	4		
	Based on observareview, the facility care and treatment assessment, presented assessment, for 1 of	tion, interview and document failed to provide appropriate tincluding comprehensive tribed treatment, and resident 3 residents (R21) reviewed sure ulcer. This resulted in 1.		R 21 was assessed on 12/16/14 current pressure areas to her he was at risk for development of pulcers. On 12/30/14 resident so 19/24 making her high risk for pulcer development. This assess showed the pressure areas on hout did not identify any other preulcers. On 12/30/14 resident was	els and ressure ored a ressure ment only er heel, ssure	
	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			to have a reddened area on resicoccyx and purplish/black areas resident s buttocks bilaterally wobserved skin slough. This was identified on the 12/30/14 asses Director of Nursing came in on at 0451 in the morning and obsearea. Director of Nursing educates identified and staff in regards to wondition and importance of reliated pressure while up in chair and in new cushion was applied to her wheelchair and air mattress to be interventions to help immediatel pressure. Resident s family initing refused physician visit, Director scheduled appointment with fam approval on 12/31/14. Physician Patient has a poor medical conchas had radiation for her tumor significant significant in the same provided appointment with fam approval on 12/31/14. Physician Patient has a poor medical conchas had radiation for her tumor significant in the same provided appointment with fam approval on 12/31/14. Physician Patient has a poor medical conchas had radiation for her tumor significant in the same provided appointment with fam approval on 12/31/14.	on the ith not sment. 2/31/15 rved ted vound eving bed. A bed as remove ially of Nursing ily s indicated ition. She	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245280	B. WING			04/	16/2015
NAME OF PROVIDER OR SUPPLIER LAKEVIEW METHODIST HEALTH CARE CENTER				6	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SUMMIT DRIVE AIRMONT, MN 56031		
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F 314	plan from the visit of a pressure ulcer of with her in detail that woundI did discuss treatment will be attered pressure on her but reluctant to have an She did become conthese particular issue worse if she does not instructions" R21 1/6/15, after she was pressure ulcer on the discharge summary readmitted to the farm of a wound vacuum stage IV pressure ulcer on the developed the stage be hospitalized, the comprehensive reat tissue after R21's redetermine what interpromote healing of help prevent further developing. An admission Minim 12/19/14, identified required extensive bed mobility, had on ulcer (the outer layer underlying layer of as remaining at risk development. Addion the CAA for presindicated R21 had a	the physician's documented note included: "PLAN 1. Stage the buttocksI did discuss at there is not an open as with her that the mainstay of tempting to relieve the ttocks. She did seem very my type of movement at all. Incerned once I discussed that uses can get progressively not follow wound care required hospitalization on as noted to have a stage IV note coccyx. The hospital of indicated she had been ucility on 1/14/15, with the use of (VAC) system to treat the user. Although R21 had not completed a sessment of the resident's eturn to the facility in order to erventions to implement to the pressure ulcers, and to resource ulcers from the pressure ulcers from the pressure ulcers from the pressure ulcers from the current stage II pressure er of skin and part of the skin is damaged or lost), and of for pressure ulcer dated 12/30/14, an "existing ulcer" on her left	F3	314	has to assume that the skin in this compromised. Following her surge patient was in the nursing home and developed an ulceration on her cook which has gotten considerably wors undermined, has significant drainag surrounding cellulitis and that started approximately 12/31/14. Resident completed personal home visits allowith therapy home visit in hope to discharge around mid April 2015. Received fax confirmation to discharge around mid April 2015. Received fax confirmation to discharge changes. Payer source benefits we not pay for silversorb dressing in homecare setting. Primary physician to want to discontinue current treat and canceled order to discharge how the due to current treatment being effect with healing wound. Assistant Director of Nursing educations who did dressing change during the state observation on appropriate measurement and dressing. R 21's plan and environment reviewed for appropriate pressure relieving interventions, Braden was completed 21's dressing was changed and reaccording to physician orders. All residents are assessed for skin breakdown daily during routine care addition, a full body audit is perform and completed during each resident bath. Infection control nurse immediately reviewed all residents with pressure to make sure policy and procedure.	ery, the decyx see, it is ge and ed had ong arge ould an did atment ome, octive ated ring so care ed. Rapplied es. In ed at s e areas were	
		ecial mattress, regular turning and needed staff assistance to			being preformed accurately. All state be educated on facility policy and	aff will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF I	PROVIDER OR SUPPLIEF	₹		STREET ADDRESS, CITY, STATE, ZIP CODE	1 01/	10/2010	
LAKEVIE	EW METHODIST HEA	ALTH CARE CENTER		610 SUMMIT DRIVE FAIRMONT, MN 56031			
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F 314	move. In addition included: "Res [re areas r/t [related to tissue perfusion, horadiation." The Coreferrals but direct plan." The Resident Incident further included: "perfusion, often redown during the down during the down during the down during the function of relied educated staff to continuous to much and a she should. Observing area approached buttocks wound. Sit too much and a she should. Observing area approached buttocks wound. Sit too much and a she should. Observing area approached buttocks wound. Sit too much and a she should. Observing area approached buttocks wound. Sit too much and a she should. Observing area approached buttocks wound. Sit too much and a she should. Observing area approached buttocks wound. Sit too much and a she should. Observing the should be a should be	rage 21 In the CAA documentation sident] is at risk for pressure of older of the color of the c	F3	procedure regarding the need for audits to be completed on resident 24 hours of admission and with of a resident returning from the The Director of Nursing complet training of a new nurse case math 4/17/15. Skin risk assessments completed on admissions, read quarterly and upon significant condition. The facility revised its and procedure for wound care to repositioning timely, assessment residents at risk for pressure ulder proper way to measure a wound need to follow physician is order wound care. The revised policy procedure for wound care also education of residents regarding integrity issues and the risk for breakdown. This policy now also steps to take if resident refuses reposition timely. Any resident pressure wounds will be audited infection control nurse for approprevention, dressing and measure procedure bi-weekly until wound resolved. The facility will monitor its perform and the effectiveness of the aborn measures through regular audit assessments related to wound skin integrity. The Director of Normal integrity is a CA committee will also the effectiveness of the measures facility is a CA committee will also the effectiveness of the measure implemented. Director of Nursing and infection control of Nursing and infection control nurse will also the effectiveness of the measure implemented. Director of Nursing and infection control of Nursing and infection control nurse will also the effectiveness of the measure implemented.	ents within n 24 hours hospital. ted inager on a will be missions, nanges in policy o address its of cers, the d, and the rs for and included g skin skin o includes to with I by priate irement I is mance ove s and care and ursing and sponsible g the The o monitor es		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245280	B. WING			04/	16/2015
	PROVIDER OR SUPPLIER W METHODIST HEA	LTH CARE CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 110 SUMMIT DRIVE FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	addressed any relurisks/consequences 12/31/14 after the cidentified. Additional documer progress report from patient will also be wheelchair and at titurning every 2 hou affected area. We a cushion that will him pressure on this are indicated to "return weeks for repeat as issues develop beform A History and Physical indicated R21 had a consult and a purulent makes for the note included included: "Patient on sufficient has been veregarding-position."	cated the first time staff had ctance with repositioning, and a associated, had been on acceyx ulcer had been on acceyx ulcer had been on a tation on the physician's in 12/31/14, included: "The encouraged to stay out of her mes lying in her bed with rs to keep pressure off this will also see if we can get her alele also prevent direct ea" The progress note also to clinic in approximately 3 assessment unless any acute ore hand." Ical (H&P) dated 1/6/15, been admitted to the hospital enous antibiotics and wound uded: "She was seen here in a reddened area on her on ulceration, her breakage noted at that timeshe has ation in the coccyx areaThe addition in the coccyx areaThe addition in the coccyx areaThe addition in the coccyx areaThe additional discharge. There is ma. There has been some and the company of the probable undermining and orous discharge. There is ma. There has been some and the company of the probable undermining and the proba	F 3	314	provided reeducation material for s effective date of correction 5/14/15		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245280	B. WING			04/	16/2015
	PROVIDER OR SUPPLIER EW METHODIST HEA	LTH CARE CENTER		610	EET ADDRESS, CITY, STATE, ZIP CODE SUMMIT DRIVE RMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	was in the nursing lulceration on her coconsiderably worse. Following R21's reasonable for the cognitive impairment extensive assistant mobility, and now halong with one stage R21's care plan, day had fragile skin, a "admission", and "of lie] down, get off borompt her to do so "Resident will have healed by next revisidentified intervention heels when in bed" a [and] cushion in the current orders - see R21's medical recoindication a compresence was hospitalized for the pressure ulcer. The Braden Scale, which rating of low or high the facility changed interventions from the stage IV ulcer on her stage IV ulcer	owing her surgery, the patient home and developed an occyx which has gotten occyx exited R21 now had moderate occ with transfers and bed ad one stage II pressure ulcer occur	F 3	14			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	LTH CARE CENTER		610	REET ADDRESS, CITY, STATE, ZIP CODE SUMMIT DRIVE RMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	R21's pressure ulceroutinely refused readmission however any education regarepositioned, until the RN-F also stated R comprehensively rerisks when she'd rerisks when she'd reressure ulcer [pressure ulcer [pressure ulcer Following this procedevice [uses medic to create negative pressure ulcer which placed." A further \$2/5/15, identified R2 decubitus ulcer loca and, "The patient [F Surgery Clinic on Jawas noted to have a unit, along with a sr coccygeal decubitu identified, "additionathe wound specialishome." The dressin appointment, so the undermining. A sub note, dated 3/23/15 the deepest along the aspect of the wound or undermining note identified, "I [nurse contact nursing hor [LPN-B] in regards."	ge 24 vere interviewed regarding er. They confirmed R21 had positioning since her the facility had not completed reding risks of not being ne breakdown on her coccyx. 21 should have been reassessed for pressure ulcer turned from the hospital. ress note, dated 1/20/15, ent [R21] underwent a ent of a coccyges decubitus er] on January 12, 2015. edure, a VAC wound care al foam and a small vacuum oressure on a wound or the facilitates healing], was Surgery progress note, dated 21 was seen for "a stage 4 ated in her coccygeal area", R21] was last evaluated in anuary 27, 2015 when she an inadequately placed VAC mall sponge within the large sulcer." Further, the note al instructions were given to set at patient's [R21] nursing ng was not removed at the e ulcer was not evaluated for osequent Surgery progress of, identified R21's ulcer "is at the left lateral and left inferior d", and, "No fistulas, tunneling ed." Further, the note practitioner (NP)-A] did ne staff and talked with to the wound dressingthey approximate 2 weeks ago by	F3	14			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 314	[PT], to obtain a for wound as the foam filling the open wou Exchange Form, da had been seen in the "coccyx ulcer", and identified, "Continuate to pack deep into le R21's condition was NP-A. A review of R21's With the following inform On 4/2/15, the presem X 1 cm in size,	am roping to place in the they have was not completely nd." A Medical Information ated 3/30/15, identified R21 ne clinic on 3/30/15 for a included a treatment which e [with] wound vac. Make sure off deep aspect of wound." Is identified as "stable" by the vound Flowsheets identified nation: sure ulcer measured 4 cm X 3 was "healing", and listed a	F3	14			
	On 4/3/15, the prescom X 0.8 cm in size to identify, "Continu On 4/8/15, the prescom X 1.5 cm in size for staff to "Continu On 4/10/15, the pre2 cm X 1.5 cm in si "healing", and for streatment."	inue current treatment." sure ulcer measured 4 cm X 3 e, was "healing", and continued le current treatment." sure ulcer measured 3 cm X 2 e, continued as "healing", and le current treatment." lessure ulcer measured 4 cm X lessure ulcer measured 3 cm X 2 lessure ulcer measured 4 cm X less					
	4/15/15 at 1:29 p.m type wound VAC dr IV pressure ulcer o was symmetrical in (beefy red tissue in approximately 50 p (necrotic tissue). T undermining on all	of pressure ulcer care, on a RN-D removed a non-coil essing and exposed a stage in R21's coccyx. The wound shape, with granulation tissue dicative of healing) and ercent (%) slough tissue he pressure ulcer had sides of the wound. RN-D and using a paper tape					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245280	B. WING		0	4/16/2015	
	PROVIDER OR SUPPLIER	ALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZI 610 SUMMIT DRIVE FAIRMONT, MN 56031	·		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 314	wound VAC kit. Rithe wound at 3 cm cm (depth). Howedepth of the wound measuring tool to ithe pressure ulceranew VAC Granuf the foam down to tand applied it into ulcer. RN-D did no pack the foam into RN-D cut a new claused the film, and applied attaches the dress. When interviewed observation of prestataches the dress. When interviewed observation of the verified she did not undermining at the prif she had any edu application of the vishe had no formal system, only havind dressings from, "When R21 had the therapist (PT)-A had education on how change; however for demonstration. Further the properties of the dress of the properties of the work of the demonstration. Further the properties of the work of the demonstration. Further the work of the work o	been included in the new N-D measured the opening of (length) X 2 cm (width) X 1.5 ver, RN-D did not measure the dat its deepest point or use any dentify the depth and degree of s undermining. RN-D opened foam Silver dressing kit and cut the size of the ulcer opening, the opening of the pressure of use a foam coil dressing, or the undermining of the ulcer. ear film, draped the ulcer using ed a new central disc piece that ing to the vacuum device. immediately after the ssure ulcer care, on 4/15/15 at ated she last observed R21's 4/6/15 and it did not have any at time. RN-D cut the new etter fit the wound today, but the pack the foam into the end wound as the physician had a ogress notes. On asking RN-D cation on the use and wound VAC system she replied education on the wound VAC g knowledge of the device and What we learned in school." The wound VAC placed, a physical and come and performed to complete R21's dressing RN-D was unable to attend the urther, RN-D stated she ssing change as she had been	F3				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245280	B. WING			4/16/2015	
	PROVIDER OR SUPPLIER	LTH CARE CENTER		STREET ADDRESS, CITY, STATE 610 SUMMIT DRIVE FAIRMONT, MN 56031	<u> </u>		
(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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 314	month prior when F an appointment wit specific instructions follow regarding the including packing the had come into the conursing home before completed correctly dressing), so she (I home and completed nurses on how to edressing change us Further, the staff wher or KCI (the marif they had question. An interview was at 4/15/15, at 2:59 p.m. the office for a period During interview on surgeon's nurse, LF regarding R21's stawas last seen on 3/ nursing home staff and place the foam aspect of the left in wound." When interviewed of stated she had nev dressing herself, but the staff and place the foam aspect of the left in wound."	seen the wound about a R21 had come to the clinic for the NP-A. The NP-A had written is for the nursing home staff to be pressure ulcer treatment, the undermining and tunnels of the VAC foam. PT-A stated R21 clinic (1/27/15) from the tre with the dressing not to the VAC wound PT-A) had went to the nursing the dadden demonstration for two complete the pressure ulcer sing the VAC foam and device. The left with instructions to call the nursing the VAC system) ins.	F3	14			
	that R21's pressur packed with the VA	ear look at it. RN-E then added re ulcer undermining should be C foam, "To heal from bottom up." RN-E was					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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F 314	completed for the schanges, but that simound from the destated the measure pressure ulcer at the documented on the likely not accurate a changes were not ophysician, it could holder, "Possibly, year The director of nurse 4/16/15, and unava R21's pressure ulcer A facility Wound Calidentified a purpose transmission of michar procedures." guidance for staff regisks of failing to registed assessment of a regulatory, or for following wound care. 483.25(d) NO CATH RESTORE BLADD Based on the resident who entersindwelling catheter resident's clinical contact catheterization was who is incontinent of treatment and service.	al education had been taff regarding R21's dressing taff should be measuring the epest part. Further, RN-E ments collected of R21's e facility which were Wound Flowsheets were especially if the dressing completed as directed by the lave worsened R21's pressure a." Sing (DON) was off campus on ilable for interview regarding er care and treatments. Are policy, dated 4/30/14, e. of, "To prevent or minimize croorganisms during wound The policy lacked any egarding when to explain the position timely, conduct sident's risk for pressure ing physician guidance for HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a sign the facility without an is not catheterized unless the prodition demonstrates that necessary; and a resident of bladder receives appropriate ces to prevent urinary tract store as much normal bladder	F3:			5/14/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER EW METHODIST HEA	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 610 SUMMIT DRIVE FAIRMONT, MN 56031			
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F 315	Continued From pa	age 29	F 31	5			
	by: Based on interview facility failed to conneed for an individual following a decline residents (R41) revisions: Findings include: R41 was admitted according to the facting faction of the facting facting for the facting facting for the facting facting for the facting facting facting facting for the facting facting for the facting	linimum Data Set (MDS) dated no cognitive impairment with a Mental Status (BIMS) score of ed extensive assistance from for toileting. The MDS indicated trial toileting program and was inent of urine and received eation. Idministration record (MAR) retic medication) 40 milligrams are per day. Idadder Evaluation indicated da diuretic, had mixed a history of incontinence, a upon rising and after meals, be episodes per week, had a licer, and perception of need to		R 41 showed a decline in corcare plan was not updated. R history of choosing to urinate and then call for assistance rausing the toilet. On 4/16/17 caimmediately updated by case Previous case manager is no facility; new case manager was on 4/16/15 in regards to update plans in to assure accuracy for of care. Infection control nurs reassessed R 41 on 4/16/15 attempted to offer R 41 a toiled schedule in which she refused education in regards to the ris with refusal. All residents will be monitored quarterly and as regards to bowel and bladder assessment, those residents conferences since 4/16/15 has bowel and bladder assessments quarterly and as insure accuracy of needs for uncontinence is addressed on Facility is installing a new election medical records system where chart and change the care pla will be immediately available for Director of Nursing and infection provided reeducation material effective date of correction 5/1	41 has a in her pad ather than are plan was manager. longer in the as educated ting care or all aspects se and eting d and was eks involved continue to a needed in function and with care ve had and all lirector of ladder and all lirector of ladder and all continuity care plan. Etronic e nurses can an; changes or all staff. ion control of for staff,		

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F 315	Continued From pa	age 30	F 315	5		
	Evaluation revealed	owel and Bladder Needs d a score of 14 which indicated e for scheduled toileting				
	R41 was at risk for related to decrease and exposure to mincontinence. The continence and dand read, "resident occasionallyhas for urinary tract infection in the continence and the	tiated on 12/2/2014 indicated alterations in skin integrity ed independence in mobility oisture from urinary care plan identified history of ecreased awareness to void is incontinent of urine uterine prolapse and is at risk ection." The care plan failed to of assistance R41 required for ividualized toileting routine or				
	indicated R41 requistaff member for to toileting program, vurine, and used a codecline from R41's incontinence. How the care plan to refincontinence that his significant change comprehensively reprogram in the presentation.	nange MDS dated 12/31/14 ired extensive assist of one illeting, did not have a trial was frequently incontinent of diuretic medication. This was a admission MDS in bladder vever, the facility did not revise lect the increase in urinary ad been coded on the MDS also the facility did not eassess the need for a toileting sence of an increase in urinary the MDS completed on				
	regards to bladder facility's Physician author was a regist	axed to the physician in incontinence written on the Orders form dated 2/25/15 and tered nurse stated R41 to get up out of bed for meals				

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	PROVIDER OR SUPPLIER W METHODIST HEA	LTH CARE CENTER		STREET ADDRESS, CITY, STATE 610 SUMMIT DRIVE FAIRMONT, MN 56031	.		
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F 315	and visits with familibreath when she go in her pad then put immediately. The promise communication by a week trial for som R41's quarterly MD required extensive toileting, was alway not on a trial toileting. The corresponding Review dated 3/31/incont. [incontinent] of Bowel. At risk for R/t [related to] Urina Again the quarterly in bladder continent revisions to the contaddress this declined. During an interview registered nurse (R not been revised to for R41. Facility policy Bower revised on 4/29/14 on the resident's confacility will ensure the bladder incontinent treatment and servinormal bowel or blad Under PROCEDUF will be assessed for voiding patters on a servinormal pattern on a	ly. States she gets short of ets up. Resident will also void call light on to be changed obysician responded to ordering a trial of Klonopin for nething to calm her down. S dated 3/25/15 indicated R41 assist of one staff member for is incontinent of urine, and was ing program. Bowel and Bladder Quarterly 15 read, "Resident remains of urine, but cont. [continent of UTI [urinary tract infection] ary incont. and diuretic use." assessment showed decline ce and again there was no inprehensive care plan to	F3	115			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
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F 315 F 322 SS=D	The resident's plan address the issue, ginterventions." 483.25(g)(2) NG TF RESTORE EATING Based on the compresident, the facility (1) A resident who halone or with assist tube unless the residemonstrates that unavoidable; and (2) A resident who i gastrostomy tube retreatment and servipneumonia, diarrhemetabolic abnorma	and/or bladder control." "4. of care will be developed to goals and appropriate REATMENT/SERVICES -	F 31			5/14/15
	by: Based on observate review, the facility for checked placement infusing medication	NT is not met as evidenced tion, interview, and document ailed to ensure nursing staff tof a gastrostomy tube prior to and formula for 1 of 1 erved to have a tube feeding		Resident R 57 was administered a feeding without proper tube placen verification prior to administration of formula. On 4/16/15 nurse was reeducated on facility policy and procedure by Director of Nursing. Policy and Procedure indicates sta	nent of Facility	

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F 322	2/11/15, identified I received "51 perce calories through the During observation on 4/16/15, at 7:50 had set up R57's manual several cups of cruroom. RN-A applied R57's bathroom, with gastrostomy tube for towel she placed of metal pole (to hand which contained a beside R57 and point of the placement of R57's stethoscope hanging infusing the medications into a syringe which she gastrostomy tube. placement of R57's stethoscope hanging infusing the medications into a syringe which she gastrostomy tube. placement of R57's stethoscope hanging infusing the medications in the step ackage, and hung allowed the tube feeling tube with the infusion of her when interviewed regards to the feed regards to the feed regards since being the wing "what I got in the step in the singular since being the singular since being the singular what I got in the singular since being the singular since being the singular since being the singular since being the singular singular since being the singular since being the singular singu	num Data Set (MDS), dated R57 was cognitively intact, and nt (%) or more" of her total e feeding tube. If of medication administration a.m. registered nurse (RN)-A nedications and brought ished oral medication into her ed a pair of non-sterile gloves in thile R57 removed a clear rom her clothing, laying it on a n her lap. RN-A brought over a graph the bad of formula from), stethoscope, kneeled down bured the prepared 60 cubic centimeters (CC) was attached to R57's RN-A did not check the graph gastrostomy tube with the ng on the metal poll prior to eations. At 8:24 a.m. RN-A tear feeding bag from the grit up on the metal pole, and reding formula to begin to strostomy tube via gravity. It check placement of the ne use of a stethoscope after dications, or before beginning	F 32	check tube placement by placistethoscope over stomach and small amount of air into enteratube. Listen for air to enter the If position of tube is not verified hold feeding and or flush and aphysician. An internal education through Educare will be assign licensed nursing staff called M Administration II Feed Tube provided additional education taking care of resident R 57. Teeding audits will be performed until accepted by QA committed currently the only resident in the with a feeding tube. Director of provided educational material effective date of correction is 5.	Instill a I feeding e stomach. d as correct, notify n program led to all edication s. This will o anyone ube d bi weekly e. R 57 is e facility f nursing to all staff,		

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 610 SUMMIT DRIVE	16/2015
610 SUMMIT DRIVE	
LAKEVIEW METHODIST HEALTH CARE CENTER FAIRMONT, MN 56031	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG 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' is 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 formulabefore administering formulabefore administering formulabefore administering formulabefore administering stormulabefore administering formulabefore feeding tubes. F 325 S25 S5ED This REQUIREMENT is not met as evi	5/14/15

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245280	B. WING		04/	16/2015
	PROVIDER OR SUPPLIER W METHODIST HEA	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 510 SUMMIT DRIVE FAIRMONT, MN 56031		
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F 325	for 1 of 3 residents for nutritional statu Findings Include: R97 was observed glasses of juice du at 9:20 a.m. Reside does not eat break good. Again on 04 was observed to eather lunch independency of green beans, 3/4 6 ounces of Ensure of green beans, 3/4 6 ounces of water. R97's quarterly Mir 3-4-15, identified d and depression. A status (BIMS) scor cognitive impairments aff member for set and 12-11-14: 117 (first 12-24-14: 107 1-29-15: 106 R97 had an 11 lbs. and 12-24-14; this The initial nutritional 12-8-15 read, " A weight 129 lbs., Residence of set and 129 lbs., Residence of R97 had an 14 lbs. Residence of R97 had an 15 lbs. Residence of R97 had an 16 lbs. Residence of R97 had an 17 lbs. Residence of R97 had an 18 lbs.	to eat her toast with two ring breakfast on 04/15/2015 ent said at this time she usually fast but said her toast tasted 4/15/2015 at 12:27 p.m. R97 at dently, ate 100% of her pork yogurt. 3/4 of yogurt. drank 4 clear, 10 ounces of milk, none 4 of potatoes and gravy about	F 325	have accurate meal intakes real R 97 will have her weights take and monitored until stable for 6 residents will be audited by CD appropriate documentation of volumetrial by CD appropriate documentation of volumetrial provided by QA committee. New dining room intake sheet was dining 5/4/15 by Director of Nursing. The process of transitioning Electronic Medical Records syswill allow for easier tracking of and food/supplement intakes of electronic MAR. Weekly weight with gains/losses will be more attracked. The certified dietary mand nursing administration will part of the interdisciplinary tear discuss at standup meetings at of concern such as weight loss of nursing and Certified Dietary provided educational material feffective date of correction is 5	en weekly 60 days. All M for weights were room on The facility g to an stem, which weights, n the ats, along accurately anager meet as m and ny changes . Director Manager or all staff;	

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F 325	plus edema in right RegularPortion si Interventions starte R97's registered did dated 12-8-14 read regular dietNotic was recently 116# [assisted living], ca [pounds]. Note poscommon. IDWR [id [pounds]. Current Enote documentati which staff writes is intakes and weight approaches are ind weight > [greater th intake of 50% or be R97's intakes were 2014 to April 2015. was not consistent, documentation four month of March 20 R97's medication a were reviewed sinc documentation resinutritional supplem time Kemps BID (twitten on the top opage. Nursing was supplement was given of the supplement was given frebruary 2015 MAI on 2-17-15, R97 prothis time the nurses the ensure clear was document amount.	armDiet Order: ze: regularNutrition d: none indicated" etician (RD) progress note , "Initial assessmentIs on a e of admit form indicated she pounds] at Woodland A.L. me to Lakeview at 129# t op [operative] hip edema is eal weight range] 121-149 # BMI [body mass index] 20.2 on of edema in her right arm, a new for her. Will monitor at to determine if nutrition licated. Will aim to hold her an] 115 lbs. and encourage etter at her meals." reviewed from December Documentation of meal intake and there was no nd for meal intakes for the 15. dministration records (MAR) e admission. There was no dent was to receive a ent until 2-12-2015. At that vice a day) with meals was f the medication administration not signing off when the ven or documenting how much was consumed by R97. The R was reviewed and indicated eferred Ensure clear and at a started to document when as given, however did not	F 3:	25		

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F 325	DX [Diagnosis]; left depression. No che Able to feed self. IE 121-149# [pounds] levels are low. Res Appetite is poor mo hungry." Goal date drink 75% of supple included, "Diet: refloor dining room. Foffer snack betwee 2-23-15) Enc. intak protein foods, 4 oz [three times a day] at am/pm, [morning supplement was ad 2-13-15. R97's registered die 12-13-15 read, "n [pounds] on 12-11-18MI [body mass in Will recommend states oz [ounces] Kemps day with med [mediated] R97's certified dieta note dated 1-12-15 Kemps BID [twice as pass." R97's registered die 2-23-15 read, "refer Was recently hospic cholelithiasis (gall secommended by the between 0-50%. W	"At risk for nutritional status. hip FX [fracture], anxiety, wing or swallowing difficulty. WR [ideal body weight range]: Total protein and albumin [resident] has lost wt. [weight]. st meals; she says she is not d 2-23-15 read R97, "will ement." Interventions gular, Provide meals to 2nd trovide set up help as needed, in meals (added to care plan e at meals, esp [especially] of [ounces] Ensure clear TID (BID [twice a day] with meds yevening] noon meal)." The ded to the care plan on etician progress note dated one her weight is down to 117#14, back to her usual weight. It is a see if she would accept 4 [supplement] 1-2 x [times] a	F3	225			

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F 325	pretty stable before [February]. Was 10 started on kemps be was ordered instead today about her apprever hungry and go to tell me she does mid-morning snack. R97's medical record documentation rever notified of R97's were RD when she required and weight leprovide any previous notification of R97's weight loss and state eater and agreed to basket to eat through stated nursing was monitor meal intake monitored R97's weight loss and stated nursing was monitor meal intake monitored R97's weight loss, because I would and she would notify I know they didn't let loss, because I would and she would notify heed to see the parresidents should be day and this is not she had talked to the had talke	e her hospital stay in feb 18# [pounds] on 2-12-15was but did not like it. Ensure clear d on 2-17-15Talked with R97 petite. She tells me she is gets full quickly. She continues n't want to eat breakfast or a	F3	225		

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F 325	a big concern." The many places to do staff is just not we stated, "Nurses sign R97's weight loss and inform us of he completed the first monitored resident. The CDM verified documentation for medical record. The aware of R97's we RD did her assess. On 4/16/15 at 2:03 stated she found in monitoring of the kRN-F stated weight R97's bath and as weight in the chart weights for weight stated if the nurse should increase from and notify dietary of this protocol was inverified R97 had at the first month of he considered R97 had at the first month of he considered R97 had at the physician regal 2-23-15, when the clear ensure 4 our stated in the considered R97 had at the physician regal 2-23-15, when the clear ensure 4 our stated in the stated R97 had at the physician regal 2-23-15, when the clear ensure 4 our stated R97 had at the physician regal 2-23-15, when the clear ensure 4 our stated R97 had at the physician regal 2-23-15, when the clear ensure 4 our stated R97 had at the physician regal 2-23-15, when the clear ensure 4 our stated R97 had at the physician regal 2-23-15, when the clear ensure 4 our stated R97 had at the physician regal 2-23-15, when the clear ensure 4 our stated R97 had at the physician regal 2-23-15.	veight for the whole month. It is no CDM stated, "There are so cument a weight, I think the ghing them." The CDM again hould have informed dietary of and I know for a fact they did er." The CDM stated the RD a nutritional assessment, and ts' weights on a monthly basis. The was no RD the month of January in the no CDM stated she became ight loss in February after the	F 32	5			
	read, "Purpose: To or lossProcedur	gning Residents undated policy maintain control of weight gain e2. All residents are weighed ekly and per doctor's order. 3.					

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F 329 SS=D	Periodic weight cheresidents with physianorexia, dehydration whenever otherwise assistants should resheets. 6. Notify physianorexia, dehydration whenever otherwise assistants should resheets. 6. Notify physians weight loss or gain lost. 7. Consult with gains weight in excellants without adequate mindications for its us adverse consequer should be reduced combinations of the Based on a compreseident, the facility who have not used given these drugs utherapy is necessar as diagnosed and crecord; and residen drugs receive gradubehavioral intervents	cks should be made on ical disorders, such as on, obesity, edema, or e indicated. 4. Nursing ecord the weights on the vitals hysician of any significant above 5 pounds gained or dietician if resident loses or ess of normal range." EGIMEN IS FREE FROM RUGS g regimen must be free from An unnecessary drug is any excessive dose (including or for excessive duration; or ionitoring; or without adequate se; or in the presence of inces which indicate the dose or discontinued; or any	F3			5/14/15

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F 329	by: Based on record refailed to identify targantipsychotic, mood psychoactive medical were affective. Also reduction/taper twice starting the medical justification as to will ack of monitoring a side effects was not of residents (R83) remedications. Findings include: R83 was admitted that according to the fact R83's facility Diseased R83 was admitted that included but we with behavioral distribution diagnosis of particles of particles and displayed behalt others one to threat assessment period assessed mood modindicating moderate MDS also indicated one staff member for the exception of behassist of two staff member for signed physician or staff member for signed physician signed phys	eview and interview, the facility get behaviors for the use and and behavior for use of cations to determine if they to attempt a gradual dose se within the first year of tion or a physician 's my it was contraindicated. Also antipsychotic medication for the done. This was noted for 1 of eviewed for unnecessary of the facility on 5/23/2014 collistives admission record. Sees Index Report revealed to the facility with diagnoses are not limited to dementia surbance and depressive toosis of Schizophrenia with was added on 5/30/14 and ranoia agitation was added on imum Data Set (MDS) dated severe cognitive impairment twioral symptoms not directed see days during the antiportion of the MDS revealed a staff conitoring (PHQ-9) score of 10 of depressive symptoms. The IR83 required extensive of or activities of daily living with dimobility where R83 required members. The deres dated 4/12/15 included hotic medication) 0.5 mg by	F 3	129	R 83 was found to not have proper behavior for the use of an antipsych and mood stabilizing medication. F was not monitoring R 83 s diagnos paranoia on the behavior monitorin sheets. New Drug review was perfuby nurse case manager and sent to primary physician for review. Previous case manager is no longer with facility, on 4/16/15 new nurse case manager corrected behavior monitors sheets and care plan to accurately diagnosis behaviors. Nurse case m reviewed residents with antipsychomood stabilizing medications to ensurance of tracking target behavior with all antipsychotic and mood stamedications. Currently all antipsychand mood stabilizing medications a with their target behaviors are addrateach care conference and quarte with consultant pharmacist reviews correction date the pharmacists psychoactive drug review every six months the facility will also provide documentation for state requirement physicians with the review on all residents with antipsychotic and mood stabilizing medications. Consulting pharmacist form with drug review will be review primary physician and audited for following policy and procedure by dof nursing this will be on going checked.	notic acility sis of gumed of the course of gumed of the cours of the course of th	

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F 329	6/23/14 and was acorder was changed November 2014. Tresident was not as extrapyramidal side Risperdal June 201 assessed after the 2014. There was respective or no Signed physician on Depakote (mood stop mouth once perhad been 7/30/14. Tregards to attempti the Depakote since on 7/30/14. There behaviors identified was affective or no Signed physician on Trazodone (antider used for insomnia) before bed and 50 asleep in one hour. was 6/17/14. The are 7/23/14. The pharm the Trazodone to 2 side effects of resid was not reduced at gradual dose taper 6/17/14 or a physician or Zoloft 100 milligrand depression. The or	The original start date was dministered twice per day; to 0.5 mg once per day in here was no indication that the assessed for potential effects after the initiation of 4 nor was there side effects dose reduction November to resident specific target at to determine if the Risperdal to determine if the Risperdal to determine if the Risperdal to day. The original start date There was no information in a gradual dose tapering of the medication was started was no resident specific target at to determine if the medication	F 329	for medication irregularities. Dir Nursing and Assistant Director provided reeducation material f effective date of correction is 5/	of Nursing or all staff;	

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F 329	week in July 2014 to f 100 mg per day. reduction attempted on Zoloft nor was thas to why it was con Zoloft. A pharmacis "family has declined reason a gradual deliance of the decision of the week, this is not attempting a dose of lacked specific resismonitor to determin R83's care plan wit 11/13/2014 identified paranoid state and R83's alertness flucture awareness and was identified target beforestlessness." The "mood and behavior in by NAR's [nursin shift." The care plan individualized intervolumentation. The cain individualized target the use of Risperdation The only behavior of was evident in the	hen it returned to current dose There was no gradual dose di twice in the first year being here a physician 's justification intraindicated to reduce the it note dated 8/8/14 included di this med change" as a cose taper was not attempted. It an acceptable reason for not reduction. Also the Zoloft dent mood and/or behaviors to be if the Zoloft was affective. The a last review date of the R83 had severe dementia, depression. It alerted staff ctuated, had a lack of safety impulsive. The care plan haviors as "crying and care plan gave the direction, or monitoring sheets to be filled grassistant registered] every in lacked identification of ventions for Zoloft and re plan lacked any the behaviors or interventions for all and Depakote. Monitoring tracking form that medical record was from the discontinuity in the condition of the condit of the condition of the condition of the condition of the condi	F3	29		

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F 371 SS=E	were not individuali behaviors of restles monitoring for depr A facility policy Pha "nurses shall monit medications dose r monitor for benefic adverse drug respolack of therapeutic response." and "Mochart a summary of the administered monitor the pharmac medication utilization shall obtain the primindicating the reast order. The goal of the should be specified the physician's program will be listed on the on behavior monitor shall define and list which shall be mon purpose of defining The attending phe psychoactive order This reevaluation is psychoactive dose outcomes and shall lowest effective cor 483.35(i) FOOD Pf	rmed. RN-E verified there zed interventions for target seness and crying for mood ession. Imaceutical Services read, or the administered esponsenurses shall ital therapeutic response, onse, common side effects, response, lack of resident onthly the nursing staff shall fobserve dose-response of redications." and "The cist shall monitor all aspects of on" and "The nursing staff mary medical diagnosis on for psychoactive medication the psychoactive drug therapy in the resident's history or in gress notes. This information pharmaceutical care plan and oring sheetsthe nursing staff it targeted behavior symptoms, intored and counted for the psychoactive dose response ysicians shall reevaluate all seat least every six months. The response, therapeutic attempt to determine the introl dose of the drug"	F3			5/14/15	
		om sources approved or ctory by Federal, State or local					

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F 371	under sanitary con This REQUIREME by:	distribute and serve food ditions NT is not met as evidenced	F 371			
	review, the facility, refrigerated food s sanitary dish storage implement a policy handling of leftove to effect 63 out of 6 Findings included: During kitchen tour guided by the certiobservation reveal cooler: 1 open bage approximately one CDM verified the dotopping and stated During the tour of the guided by the CDM bowl dry storage rathat were wet betweet glasses that we tray of glasses that were yet glasses that were drained or contained a stack off the rack and tip of water drained or contained visible we plates contained dethe dishes were we supposed to be dry	tion, interview, and document failed to ensure safe torage, failed to ensure ge, and failed to develop and and procedure for safe food r foods. This had the potential 64 residents. Ton 4/13/15 at 3:10 p.m. fied dietary manager (CDM) ed the following in the reach in of whipped topping half gone dated 3/4/15. The ate on the bag of whipped it should have been discarded. The dry dish storage area 1, observation of the cup and ack revealed a stack of 4 bowls een the stacked bowls and 23 ere upside down and an entire to were stored upside down that on the inside. The rack of wet glass bowls, when taken ped to the side a small amount at. A stack of 4 divided plates rater and one of the sanitized ried food debris. CDM verified et, and explained dishes were we prior to putting them away. The how long the dishes had		Facility failed to ensure sanitary dis storage, and failed to develop and implement a policy for safe food har of leftover foods. CDM met with all staff on 4/17/15 to review dietary pound 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 to freight person will be assigned by Caudit freezer and refrigerator. No peremains on shelf if beyond 7 days of opening. (4/17/15 CDM) CDM will assweekly for 12 weeks. B. CDM ordered new dish rack white arrived on April 30th and are now in These new racks will assure that distand juice glasses are air dried (4/30 CDM) C. On 4/22/15 Maintenance staff me knife rack to kitchen wall above sink where it will remain. D. On 4/17/15 a new policy was developed, by CDM for leftovers, where it will remain. D. On 4/17/15 a new policy was developed, by CDM for leftovers, where it will remain. D. On 4/17/15 a new policy was developed, by CDM for leftovers, where it will remain. D. On 4/17/15 a new policy was developed, by CDM for leftovers, where it will remain. D. On 4/17/15 a new policy was developed, by CDM for leftovers, where it will remain. D. On 4/17/15 a new policy was developed, by CDM for leftovers, where it will remain. D. On 4/17/15 a new policy was developed, by CDM for leftovers, where it will remain. D. On 4/17/15 a new policy was developed, by CDM for leftovers, where it will remain. D. On 4/17/15 a new policy was developed, by CDM for leftovers, where it will remain. D. On 4/17/15 a new policy was developed, by CDM for leftovers, where it will remain.	ndling dietary blicies ng: f fer he DM to roduct of audit ch use. shes 0/15 noved cs, hich vings s be depth	

CENTE	45 FOR MEDICARE	& MEDICAID SERVICES			U	<u>NR NO.</u>	0938-0391
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LAKEVIE	EW METHODIST HEA	LTH CARE CENTER			10 SUMMIT DRIVE AIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	attached to the side bottom of the knife holder was 8 is was removed from heavily soiled with gwell as dried debris During an interview answer to the queshandling leftover fo there was more that would put in shallow refrigerator to be us. The CDM stated the during the cooling paware of the proced temperatures and the During an interview same question was stated leftovers were then placed in the cotake temperatures of C-A was unable to prevent food borne foods. C-A stated the second choice of C-A stated temperatures had refurther explained not temperatures had refurther foods other Control (pertaining "Leftover foods will covered containers immediately in cool	dry racks. stored in a knife holder of a preparation table. The holder was not enclosed. The inches off of the floor. A knife the holder and found to be gelatinized yellow debris as . CDM verified knife was dirty. on 4/16/15, at 10:29 a.m. in tion "What is your process for ods?" the CDM explained if in 12 servings of leftovers they we pans and placed in the sed within the next few days. ey did not take temperatures process. The CDM was not dure to ensure safe imes for cooling left overs. on 4/16/15 at 10:42 a.m. the re placed in shallow pans and cooler. C-A stated they do not during the cooling process. explain the safe handling to illness for cooling leftover ne leftovers are then used for entrée at the next day's meal. atures of second choice foods r reheated or recorded and of recording those	F3	371	used and temps will be taken until to 140F 70F. All staff in dietary vinstructed in this method on 4/17/1 CDM. CDM will audit weekly for 12 weeks. E. On 4/17/15 CDM developed a temperature log for all second choi menu items, and trained dietary stause. CDM will audit for 12 weeks. Director of Nursing and Assistant of Nursing will be responsible for reeducation of policy and procedur all nursing staff on 5/15/15/ effective of correction is 5/14/15.	vas 5 by ce aff to virector es for	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMPLETED	
		245280	B. WING _		04/	16/2015
	PROVIDER OR SUPPLIER	TH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 610 SUMMIT DRIVE FAIRMONT, MN 56031	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
	hours, after which ti Food temperature le January through Ma reflect any second of were obtained even meal time. Facility policy Food which have opened an enclosed contain Expiration dates on well as the refrigera regular basis and for discarded." Facility policy Dishw "Dishes are to air di Dishes/glassware w contamination by er covered in a dish lo Facility policy Infect not dated) read, "Fo Washing 9. All dishe stored in clean, dry, 483.60(a),(b) PHAF ACCURATE PROC The facility must pro drugs and biological them under an agre §483.75(h) of this p	must be consumed within 72 me they will be discarded" ogs were reviewed from arch 2015. The logs did not choice entrée temperatures though they were offered at Storage (no date) read, "Food or prepared will be placed in ner, dated, and labeled. all foods in the storeroom as ator will be checked on a cod/fluids which have expired vashing signed 2/2012 read, ry before storage or use. vill be protected from nclosed storage or being werator." ion Control (Dietary function, ood Service and Ware es, silverware, etc. Will be and enclosed storage." RMACEUTICAL SVC - EDURES, RPH Divide routine and emergency lis to its residents, or obtain ement described in art. The facility may permit	F 37	71		5/14/15
	law permits, but onl supervision of a lice A facility must provi (including procedura acquiring, receiving	ensed nurse. de pharmaceutical services es that assure the accurate				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	` '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		245280	B. WING _	·····	04/	16/2015	
	PROVIDER OR SUPPLIER	ALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 610 SUMMIT DRIVE FAIRMONT, MN 56031			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 425	a licensed pharma on all aspects of the services in the fact	resident. mploy or obtain the services of cist who provides consultation he provision of pharmacy lity.	F 42	25			
	by: Based on observareview, the facility labeling of medicar R14, R57) observed the survey, and 1 of for unnecessary management of the survey, and 1 of for unnecessary management of the survey and surveyed a daion order of the surveyed and orders from Doctor on an order of, "[chandosing to 2 units/1 with meals, per result of the surveyer and r	Minimum Data Set (MDS), ified R104 had intact cognition, ly insulin injection. R104's or fax, dated 3/31/15, identified ge] Novolog rapid acting insulin 5 gram carb. [carbohydrates]		Facility did not identify the chamedication label on an insulin drop vial. Facility was administ medication according to the ploorder but did identify the chanmedication label. On 4/15/15 Director of Nursing updated allabels for affected residents in by drawing a line through the label and indicating a order chacility policy. Assistant Direct nursing educated staff in regarchanges and medication label labels being inaccurate. Facilipolicy and procedure by drawithrough the medication label a indicating that there is a medication carts to make sure medication labels matched labels and procedure states that the be corrected with the next ord medication. Facility will audit bit weekly for 90 days to make solutions are being sustained approval from QA committee.	vial and eyestering the hysician is ge on the Assistant I medication mediately medication ange per cor of the total or order it will following a line and eation order hrough eithat bels on lity policy labels will ering of the medications sure that until		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245280	B. WING		 	04/-	16/2015
	PROVIDER OR SUPPLIER EW METHODIST HEA	LTH CARE CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 10 SUMMIT DRIVE AIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	LPN-H prepared the physician order, and When interviewed of LPN-H stated she copreparing the insuli with you, I did not lot is incorrect" and shobtain a new label is medication error. R14's quarterly MD R14 was cognitively Medication List, dath order of, "OCULAR (THERATEARS OF DROPS, EYES (BC) During observation on 4/14/15, at 11:4' eye drops and provisurveyor which read EYES FOUR TIME DRY EYES." There label to alert staff to updated 11/15/14. The label and order label was not accur pharmacy. Further nurse is assigned to labeling, however staffing hours, it was completed. R57's annual MDS, was cognitively into anti-anxiety medical Sheet, dated 4/7/15	e insulin according to the d administered it to R104. on 4/14/15, at 11:28 a.m. did not read the label prior to n for injection, "I'll be honest ook at that." Further, the "label e would notify the pharmacy to n order to reduce the risk of a S, dated 1/21/15, identified y intact. R14's Discharge ted 11/15/14, identified an	F 4	-25	be completed by charge nurse and nursing administration. Director of and Assistant Director of Nursing produced reeducation material for staff member, effective date of coi is 5/14/15.	Nursing each	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONS	(X3) DATE SURVEY COMPLETED			
		245280	B. WING			04/	16/2015
	PROVIDER OR SUPPLIER	LTH CARE CENTER		610 SUN	ADDRESS, CITY, STATE, ZIP CODE MMIT DRIVE DNT, MN 56031	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 425	[tablet] 1/2 [one hal Endoscopic Gastro During observation on 4/16/15, at 7:50 prepared R57's at a package was provid "LORAZEPAM [Ativ TABLET VIA [by wa There was no modi staff to refer to the for use of half table regarding the label stated the label was had been faxing the changed for over a completed yet. Fur protocol is to get a R10's Humalog me currently in use rea subcutaneously in t subcutaneously in t subcutaneously at 1 dispense date of 4/ R10 had diagnosis mellitus. R10's phy 2/10/15, revealed o seven (7) units at 8 p.m., and three (3) physician order for at 12:00 p.m. had a physician order for at 6:00 p.m. had a showever, the label six (6) units at 12:0	of medication administration a.m. registered nurse (RN)-A mobile cart. The Ativan ded to the surveyor and read, ran] TAB 0.5 MG TAKE 1 may of] PEG TWICE DAILY." fication to the label to alert physician orders dated 4/7/15 to f Ativan. When questioned and order discrepancy, RN-A month, but it had not been ther, RN-A added, "Our new label." dication label on the vial d, "inject 7 units he morning; inject 6 units moon." The insulin had a 2/15. that included diabetes resician orders signed & dated reders for Humalog insulin to a.m., five (5) units at 12:00 units at 6:00 p.m. The Humalog insulin five (5) units a start date of 6/28/14. The Humalog insulin three (3) units start date of 2/11/14. for Humalog should have read 0 p.m. or noon. Also the label 6:00 p.m. dose of three (3)	F 4	25			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245280	B. WING			04/	16/2015	
	PROVIDER OR SUPPLIER W METHODIST HEA	LTH CARE CENTER		610 SUM	ADDRESS, CITY, STATE, ZIP CODE MIT DRIVE ONT, MN 56031			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 425	administration recorevealed R10 receired R10 received R10	of the facility medication rd for 4/1/15 through 4/14/15, wed insulin as ordered. If blood sugar reports faxed to 20/14, 12/3/14, 1/28/15, 1/15, and 3/25/15, each wed Humalog insulin doses as 4/16/15, at 9:30 a.m., 1/10/15 and that the label 2/15 and that the label 2/15 and that the label 3/10 units in the morning and 6/10 interview at that time, RN-E abel did not include three units a sysician ordered. RN-E verified blude the current physician at 12:00 p.m. RN-E stated she notify the pharmacy when	F 4	25				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245280	B. WING		04/	16/2015
	PROVIDER OR SUPPLIER W METHODIST HEAI	TH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 610 SUMMIT DRIVE FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 425	large black line or X	sses the existing label with a (."	F 425			
F 428 SS=D	483.60(c) DRUG R IRREGULAR, ACT	EGIMEN REVIEW, REPORT ON	F 428			5/14/15
		of each resident must be noce a month by a licensed				
	the attending physic	st report any irregularities to cian, and the director of reports must be acted upon.				
	by: Based on observat review, the facility fa pharmacist identifie psychoactive medic physician follows up 5 residents (R83) re medications. Findings include: R83 was admitted t according to the face R83's facility Diseas R83 was admitted t that included but we with behavioral dist disorder. The diagn acute exacerbation the diagnosis of par 6/27/14.	ion, interview, and document ailed to ensure the consultant dirregularities for eation use and that the on recommendations for of eviewed for unnecessary of the facility on 5/23/2014 collity's admission record. Sees Index Report revealed to the facility with diagnoses are not limited to dementia curbance and depressive osis of Schizophrenia with was added on 5/30/14 and ranoia agitation was added on timum Data Set (MDS) dated		R 83 was found to not have proper behavior for the use of an antipsych and mood stabilizing medication. F was not monitoring R 83 s diagnos paranoia on the behavior monitoring sheets. Previous nurse case mana no longer with the facility, on 4/16/1 nurse case manager corrected beh monitoring sheets and care plan to accurately track diagnosis behavior Education was done by assistant D 4/16/15 in regards to importance of tracking target behaviors with all antipsychotic and mood stabilizing medications. Currently all antipsycl and mood stabilizing medications a with their target behaviors are addressed care conference and quarterly consultant pharmacist reviews. As	notic Facility sis of gager is 5 new lavior cs. ON on the colong ess at y with	

PRINTED: 06/02/2015 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE &	MEDICAID SERVICES			JMB NO.	<u>0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		SURVEY PLETED
	245280	B. WING _		04/1	16/2015
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKEVIEW METHODIST HEALT	H CARE CENTER		610 SUMMIT DRIVE FAIRMONT, MN 56031		
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
and displayed behaviat others one to three assessment period. Tassessed mood monindicating moderate of Signed physician order Risperdal (antipsychomouth once per day find paranoia/agitation. The 6/23/14 and was admorder was changed to November 2014. The resident was not assessed after the document of the company of the	evere cognitive impairment foral symptoms not directed e days during the The MDS revealed a staff itoring (PHQ-9) score of 10 depressive symptoms. ers dated 4/12/15 included offic medication) 0.5 mg by for diagnoses of the original start date was ninistered twice per day; to 0.5 mg once per day in the ere was no indication that the	F 42	,	ents for or of Nursing of ng staff ction is er target chotic Facility osis of ng fumed to vious with the entoring y track manager otic and nsure no lee by reds to aviors abilizing chotic along dressed terly	

was not reduced at this time and there was no

documentation for state requirements for

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		245280	B. WING			04/1	16/2015
	PROVIDER OR SUPPLIER EW METHODIST HEA	LTH CARE CENTER		61	REET ADDRESS, CITY, STATE, ZIP CODE O SUMMIT DRIVE AIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	6/17/14 or a physic the gradual dose to the gradual dose to this time. Signed physician of Zoloft 100 milligrand depression. The orpre-hospitalization. Zoloft be reduced to week in July 2014 to f 100 mg per day. The reduction attempted on Zoloft nor was to as to why it was congramily has declined reason a gradual dowever, this is not attempting a dose of lacked specific resimplity and the monitor to determine the only behavior of was evident in the off March 2015 and has depression. The talk crying/restlessness listed were generic documentation reflerestless for the monitoring an interview (RN)-E verified the target behaviors and had not been performed were not individual behaviors of restless monitoring for depression of the was no evide any follow up with the signer of the second of the	done since ordered on ian 's justification as to why pering was contraindicated at orders dated 4/12/15 included as (mg) every day for iginal start date of Zoloft was. The physician had ordered to 50 mg per day times one then it returned to current dose. There was no gradual dose of twice in the first year being there a physician 's justification intraindicated to reduce the stanted to the sta	F 4	28	physicians with the review on all reviews case manager will fill out quadrug review on all residents with antipsychotic and mood stabilizing medications. Consulting pharmacis form with drug review will be review primary physician and audited for following policy and procedure by conformation irregularities. Direct Nursing and Assistant Director of Nursing and Assistant Director of Provided reeducation material for a effective date of correction is 5/14/	arterly at's yed by lirector cking or of lursing ll staff;	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	E SURVEY MPLETED
		245280	B. WING		04/	/16/2015
	PROVIDER OR SUPPLIER	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 441 SS=E	A facility policy Pha "nurses shall monit medications dose r for beneficial therapy response, common therapeutic response and "Monthly the nusummary of observadministered medic pharmacist shall medication utilization 483.65 INFECTION SPREAD, LINENS The facility must est Infection Control Presafe, sanitary and to help prevent the of disease and infection Control The facility must est Program under white (1) Investigates, coin the facility; (2) Decides what preshould be applied to (3) Maintains a reconstructions related to infection Control The facility; (2) Decides what preshould be applied to (3) Maintains a reconstruction of the facility; (2) The facility must est (3) The facility must est (4) The facility must est (5) The facility must est (6) The facility must est (7) The facility must est (8) The facility must est (9) The facility must est (1) The facility mu	endation on 2/13/15. rmaceutical Services read, or the administered esponsenurses shall monitor beutic response, adverse drug side effects, lack of se, lack of resident response." ursing staff shall chart a re dose-response of the cations." and "The consultant onitor all aspects of on." I CONTROL, PREVENT Itablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction. I Program rtablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, or an individual resident; and ord of incidents and corrective effections. Rad of Infection cion Control Program resident needs isolation to of infection, the facility must	F 4	28		5/14/15

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245280	B. WING			04/-	16/2015
	PROVIDER OR SUPPLIER	ALTH CARE CENTER		61	REET ADDRESS, CITY, STATE, ZIP CODE O SUMMIT DRIVE AIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETION	
F 441	direct contact will (3) The facility mu hands after each of hand washing is ir professional pract (c) Linens Personnel must ha	t with residents or their food, if transmit the disease. st require staff to wash their direct resident contact for which adicated by accepted	F 4	.41			
	by: Based on observareview, the facility and symptoms of disease did not provide which had potentiaresiding on the seensure staff wore equipment during 2 residents (R35) glucose checked of the facility failed to passed water to remethod which had residents on the sable to drink water Findings include: During observation licensed practical mobile medications for the same control of t	eNT is not met as evidenced ation, interview, and document failed to ensure staff with signs potentially communicable ovide services for residents at to affect 18 of 34 residents cond floor of the facility, and to appropriate protective a blood glucose check for 1 of observed to have their blood during the survey. In addition, o ensure outside volunteers esidents using a sanitary I potential to affect all of the econd and third floors who are for an on 4/15/15, at 7:27 p.m. nurse (LPN)-I was standing at a cart in the hallway preparing e North and South wings of the I-I had audible congestion, and			Facility failed to ensure an ill staff member did not provide services. (facility found out employee was ill facalled and replaced employee. On 4/15/15 employee LPNI was reedue on the policy and procedure by direction on the policy and procedure by direction of protocol for sick employees. All employees will continue to be educated with Educare annually and as needed infection control. Staff did not wear proper personal protective equipment while administering a blood glucose 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 gloves or disinfect their hands betwee administering water mugs to reside On 4/16/15 assistant director of nureducated staff on proper infection of techniques in obtaining blood glucose.	cated ctor of control ated ed on ent etest.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245280	B. WING			04/	16/2015
	PROVIDER OR SUPPLIER EW METHODIST HEA	LTH CARE CENTER		61	REET ADDRESS, CITY, STATE, ZIP CODE O SUMMIT DRIVE AIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	stated she had a so head hurts." She h symptoms, including checked her temped degrees Fahrenheishe should not be was ill, "If I have a there." When interviewed oregistered nurse (Fare not to be working fever, "That's just the state of the self as having a not wear any glove medication for resident preparation of the state of th	ore throat adding, "My whole and developed these of a fever, on 4/14/15. LPN-I stature, and had a fever of 99.2 troit (F). Further, LPN-I stated working with residents as she fever, I probably shouldn't be on 4/15/15, at 7:34 a.m., and they are ill and/or have a ne policy." be b	F4	41	On 4/21/15 volunteer director education MRCI volunteer and all support staff proper technique of hand washing a glove wearing. Education included the each volunteer will put on a new pair gloves and hand sanitizer in betwee 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 receivant infection control education annually through Educare, at time of hire and needed. Facility will perform CBG audits bi-weekly to make sure infection control/PPE techniques are being followed. Human Resources can make 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 a will continue until approved by QA committee. Director of Nursing and infection control nurse have provide reeducation to all staff; effective date correction is 5/14/15.	f on and that r of en s, ere ve d as	

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		245280	B. WING _		04	/16/2015	
	PROVIDER OR SUPPLIER W METHODIST HEA	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 610 SUMMIT DRIVE FAIRMONT, MN 56031			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 441	gathered her belon A facility Employee policy, dated 4/29/- including, "To reduce infectious agents to frail resident or to co identified a procede employee may repo other contagious desired for 24 hours. LACK OF PROTECE GLUCOSE CHECK R35 was observation when licensed prace R35's finger with a which contains a ne blood) and squeeze hands exposing bloo on the testing strip returned to the men have any gloves or check. When interviewed LPN-H stated she is check R35's blood get to the lunch me she can go." During interview or registered nurse (F trained to wear glor glucose monitoring	ts until 9:30 a.m. when she gings and left the floor. Health Infection Control 14, identified a purpose ce the potential transmission of the physically or medically co-workers." Further, the policy ure which included, "No cort to work with a feveror isease until you have been s." CTION DURING BLOOD	F 44				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245280	B. WING		04	/16/2015
	PROVIDER OR SUPPLIER	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 610 SUMMIT DRIVE FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 441	4/29/14, identified a on non-sterile glove sample. LACK OF SANITAL RESIDENTS: During an observativater pass perform from an outside aghygiene practices to cross contamination residents. On 4/15/15, at 9:27 entered resident roof hand placed on water cup; VOL-C of the lid where the water from cup. VO restroom sink, and placing the rim of the put the lid on the sink and the water to room and hapalmed the lid; VO area on lid. VOL-A water cooler on a clid of the cup and the again. VOL-C stool and waited for cup to touch face, hair, un-wrapped a drinkends. VOL-A hand VOL-C placed the water to room 355. On 4/15/15, at 9:34 room 310. VOL-D placed the water to room 355.	cose Monitoring policy, dated a procedure which read, "Put es" prior to obtaining a blood RY WATER PASS TO tion of the third floor morning ned on 4/15/15 by volunteers ency, revealed a lack of hand to reduce the risk of possible on and spread of infection to a.m. Volunteer (VOL)-C from 355, palmed (entire palm top of lid to open) the lid of the hand touched the drinking area to resident would put lips to sip DL-C carried the cup to the tipped the cup upside down the cup on the bathroom sink, after touching the outside of ater faucet, then carried it out unded it to VOL-A. VOL-A L-A again touched the drinking filled the cup with water via cart. VOL-A then replaced the ouched the drinking area d on the other side of VOL-A to be filled and was observed and water cart. VOL-C then king straw and touched both ed VOL-C the water cup. straw in the cup and returned	F 44			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245280	B. WING		04	/16/2015	
_	PROVIDER OR SUPPLIER EW METHODIST HEA	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	'E ACTION SHOULD BE COMPI D TO THE APPROPRIATE DA		
F 441	with her forefinger VOL-D dumped the the bottom of the cink, and then palm VOL-D then returned the room and has VOL-A then palmed area. VOL-A then for the lid back on; tou lid. VOL-D had beed cart touched her clumwrapped and tou VOL-D returned the No observations we practicing safe hand observations, the staff educated on land I residents had compared to the control stated expended in the stated of the control stated expended in the stated volunteers were control to volunteer what topics were control portion of of activities director pouring an interview activities director or the outside agency orientation to the factor of the control to the fac	arried the cup to the restroom inside the cup holding onto it. e water out of the cup, touched up to the drain grate in the ned the lid and put it back on. ed to the cart that was outside unded the water cup to VOL-A. It is discovered to the drinking illed it with water and placed uched the drinking area of the en standing next to the water othes and the water cart, then uched both ends of the straw. It is ewater glass to room 310. It is every made of volunteers and hygiene during these water pass was ceased and ack of sanitary practice used. It is dean cups exchanged for soiled are on 4/15/15, at 9:36 a.m. and the water pass had not	F 4	41			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245280	B. WING		04/	16/2015	
	PROVIDER OR SUPPLIER	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 465 SS=E	residents. AD-I state of orientation did converified volunteers received orientation supervisor were suprovide oversight at The facility's Volunt dated 6/14/00 read washing procedure A policy pertaining requested and not 483.70(h) SAFE/FUNCTION/E ENVIRON	e second and third floor ed the infection control portion over hand hygiene. AD-I that were present had a. AD-I stated, the volunteer's opposed to be trained as well to and guidance when needed. eer Orientation Checklist a "Infection control (hand a)." to hand hygiene was received. AL/SANITARY/COMFORTABL ovide a safe, functional, ortable environment for	F 4			5/14/15	
	by: Based on observareview, the facility fequipment in a san residents. This had of 64 residents that Findings include: During the tour of the certified dietary at 3:10 p.m. The collayer of gray dust, thad an overall sme They had a layer of substance and crurstainless steel belo	ition, interview, and document ailed to maintain food service itary manner for 63 out of 64 the potential to effect 63 out resided in the facility. The facility's kitchen guided by manager (CDM) on 4/13/15, provection oven tops had a the faces or fronts of the ovens ared with debris appearance. black greasy appearing the oven door. The inside is showed rust areas with a		Facility failed to maintain food se equipment in sanitary manner. Al affected equipment was cleaned immediately by dietary staff by dir CDM on 4/17/15. Total kitchen was cleaned the week of April 20th unsupervision of CDM A. Cleaning schedule was revis CDM listing every piece of equipm assigning specific duties to specific dietary staff members. CDM reviewith all staff the week of April 19th assure that each person understocleaning process and products to used. CDM will audit weekly for 1	ection of as deep der ed by nent and ic ewed in to lood be		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		245280	B. WING			04/ ⁻	16/2015
	PROVIDER OR SUPPLIER W METHODIST HEA	TH CARE CENTER		6	TREET ADDRESS, CITY, STATE, ZIP CODE 110 SUMMIT DRIVE FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 465	The ovens located had oven racks set underneath the rack debris and dust. The smeared with debris and legs, where the bow around the legs of the beater would be attended food debris and dried food debris appliances including processor, a mixer cluttered and had freedge. The microwal built up of food debris the door latch. The where the beater whildup of dark debris and the dishwasher with debris. The microwal buildup of debris to buildup of deb	plack debris build up. next to the convection ovens on top of oven and ks the oven surfaces had dried e fronts of the ovens were in appearance. d dried debris and dust on the vi connects to the mixer, and he mixer. The area where the ached showed yellow ill/oven faces were soiled and ris underneath. Table that had small g a microwave, a food and a blender on top was bood debris along the back we had small area of rust and ris on the left hand side near underside of the small mixer ould be attached showed a ris. The area were extremely soiled top boards or base boards that hen were soiled with a black he grouted areas of the tile seboards showed black or. The area were extremely soiled on 4/16/15, at 10:30 a.m. same findings as outlined on 4/16/15, at 11:26 a.m. hing schedule is used and flow the schedule. CDM tenance department pressure ance a month and sometimes	F4	165	weeks. A disadvantage is that the the kitchen is the color black. The cleaning schedule was reviewed wi maintenance and CDM on 4/17/15. Kitchen floors are cleaned every ot Friday, with the 2nd Friday being a wash. One was done on 4/17/15. will do weekly audit and report to maintenance director if additional wineeded. Effective date of correction is 5/14/	floor th her power CDM vashes	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DAT COM	(X3) DATE SURVEY COMPLETED	
		245280	B. WING		04.	/16/2015
	PROVIDER OR SUPPLIER	LTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIF 610 SUMMIT DRIVE FAIRMONT, MN 56031		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 465	The facility cleaning staff to clean work a schedule did not give	g schedule gave direction to area daily. The cleaning we details of surface areas or work area" that may need daily	F 4	65		

DEPARTMENT OF HEALTH AND HUMAN SERVICES F 5 2800 24 CENTERS FOR MEDICARE & MEDICAID SERVICES F 5 2800 24

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

Printed: 05/04/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION	DENTIFICATION NUM	MBER:	A. BUILDING	01 - MAIN BUILDING 01	COMPLETED
	245280		B. WING		04/28/2015
NAME OF PROVIDER OR SUPPLIER LAKEVIEW METHODIST H	EALTH CARE CENT	610 SUN	ESS, CITY, ST MMIT DRIV NT, MN 50		
PREFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIE IT BE PRECEDED BY FULL I ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
K 000 INITIAL COMMEN	TS		K 000		
FIRE SAFETY					
Minnesota Departr Fire Marshal Divisi time of this survey Methodist Health (substantial complia participation in Me Subpart 483.70(a) 2000 edition of Na Association (NFPA Code (LSC), Chap Occupancies. Lakeview Methodis constructed as folla Building 01 consist buildings. Building has a partial baser protected and was II(111) construction Building 02 represe consists of a chape offices, mechanica assisted living facil in height, has a pa sprinkler protected Type V(111) constructed 2-hour fire wall ass buildings of Type II addition of Type V(nursing home from Opening protective	is of the 1963, 1978 at 01 is three stories in ment, is fully fire sprin determined to be of 1; ents the 2000 additionel, main entrance, but I room and a link to a ity. This addition is ortial basement, is fully and was determined	State 5 At the riew of to be in ments for CFR, and the Safety h Care was and 1993 height, kler Type n, and siness n ne-story fire to be of the menthe of the cility.			
In accordance with	NFPA 101 (2000) Ch	apter 19,			
LABORATORY DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESE	NTATIVE'S SIGN	ATURE	TITLE	(X6) DATE

(X2) MULTIPLE CONSTRUCTION

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.

Printed: 05/04/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER 1				LE CONSTRUCTION : 01 - MAIN BUILDING 01	(X3) DATE S COMPL		
		245280		B. WING		04/2	28/2015
	ROVIDER OR SUPPLIER	TALTU GARE GENT			TATE, ZIP CODE		
LAKEVI	WETHODIST HE	EALTH CARE CENT		MMIT DRIV DNT, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 000	V(111) construction facility was surveyed Form CMS-2786R The facility has a find detection in the concorridors, which is a department notifical	age 1 aree-story building of a is not permitted. As the das two-buildings, a booklets were complere alarm system with tridors and spaces opmonitored for automation. The facility has and had a census of the day of the da	s such, the and two eted. smoke ben to the atic fire a	K 000			
:							

F5280024

(X2) MULTIPLE CONSTRUCTION

Printed: 05/04/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				PLE CONSTRUCTION G 02 - THE CHAPEL	(X3) DATE SURVEY COMPLETED			
		245280		B. WING		04/2	04/28/2015	
	ROVIDER OR SUPPLIER W METHODIST HE	EALTH CARE CENT	610 SU	RESS, CITY, S MMIT DRIN DNT, MN &				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL R ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
	INITIAL COMMEN' FIRE SAFETY A Life Safety Code Minnesota Departn Fire Marshal Division time of this survey, Methodist Health Country substantial compliat participation in Medic Subpart 483.70(a), 2000 edition of Nath Association (NFPA) Code (LSC), Chap Occupancies. Lakeview Methodist constructed as follow Building 01 consists buildings. Building has a partial basen protected and was II(111) construction Building 02 represe consists of a chape offices, mechanical assisted living facili in height, has a par sprinkler protected Type V(111) construction 2-hour fire wall association of Type II(addition of Type II(addition of Type V(nursing home from	Survey was conducted nent of Public Safety, on, on April 28, 2015. Building 02 of Lakevidare Center was found ince with the requiremedicare/Medicaid at 42 Life Safety from Fire, ional Fire Protection Standard 101, Life Safety from Fire, ional Fire Protection Standard 101, Life Safety from Fire, ional Fire Protection of the 1963, 1978 are 19 Existing Health of the Health Care Center was: In the stories in Intent, is fully fire sprink determined to be of Tigents the 2000 addition, and massisted living facility and was determined to the cuction.	State At the ew I to be in eents for CFR, and the afety Care was nd 1993 neight, aler ype and iness ne-story fire to be of	K 000	DEFICIENCY)			
	assemblies.	e latching, 90-minute						
LABORATO		NFPA 101 (2000) Cha		LIATI INT	T 17 P		(Va) DATE	
LABURATOR	(Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESEN	HATIVE'S SIGI	NATURE	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.

Printed: 05/04/2015 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA MBER:	1	02 - THE CHAPEL	(X3) DATE S COMPL	SURVEY LETED
		245280		B. WING		04/2	28/2015
3	PROVIDER OR SUPPLIER EW METHODIST HI	EALTH CARE CENT	610 SU	RESS, CITY, ST MMIT DRIV DNT, MN 5		·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCII T BE PRECEDED BY FULL I ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
K 000	V(111) construction facility was surveyed Form CMS-2786R The facility has a find detection in the concorridors, which is department notification.	nree-story building of in is not permitted. As ed as two-buildings, a booklets were complained ire alarm system with rridors and spaces of monitored for automa ation. The facility has s and had a census of	s such, the and two leted. smoke pen to the atic fire a	K 000			



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 <u>only a suggestion</u> 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

Lakeview Methodist Health Care Center May 4, 2015 Page 2

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,

Kumalu 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

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

(X6) DATE

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00360	B. WING		04/16/2	015
	PROVIDER OR SUPPLIER	TH CARE CENT! 610 SUM	DRESS, CITY, S MIT DRIVE T, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) OMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the deficing herein are not corrected shall with a schedule of the Minnesota Department o					
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been compliance with all a rule provided at the tag alle number indicated below. In several items, failure to the items will be considered a Lack of compliance upon any item of multi-part rule will ament of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 05/13/15

TITLE

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00360	B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKEVIE	EW METHODIST HEA	TH CARE CENTI	MIT DRIVE T, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	you electronically. is necessary for State enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Departm On April 16, 2015, staff, visited the absorrection orders a your electronic plant.	surveyors of this Department's ove provider and the following re issued. Please indicate in of correction that you have ers, and identify the date when				
	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.					
	column entitled "ID statute/rule out of co "Summary Statement and replaces the "To correction order. The findings which are in after the statement evidence by." Follow	umber appears in the far left Prefix Tag." The state ompliance is listed in the ent of Deficiencies" column o Comply" portion of the nis column also includes the n violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rection.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00360	B. WING		04/1	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
LAKEVIE	W METHODIST HEAL	TH CARE CENTI	MIT DRIVE NT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			5/14/15
	Subp. 3. Use. A co	omprehensive plan of care personnel involved in the				
	by: Based on observati review, the facility fa was followed for 1 c	ent is not met as evidenced on, interview and document ailed to ensure the care plan of 1 resident (R97), who was o place hearing aids for use.		Completed on 5/14/15		
	Findings Include:					
		imum Data Set (MDS) dated 7's ability to hear was ise of a hearing aid.				
	hearing is adequa [bilateral] aides." In place hearing aids on nurse was to check functioning properly	ted 03/15/13, read, to communicate needs ate with the use of bilat a addition it directed staff to daily in the morning and the to ensure they were and batteries were charged ang aids were working.				
		p.m. during an interview with (FR)-A present, R97 was				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00360	B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKEVIE	EW METHODIST HEA	ITH CARE CENTI	MIT DRIVE NT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 565	observed to not have place. FR-A stated are often not in whe FR-A said she visits. On 4/16/15 at 9:30 sitting in her recline newspaper and agabeen placed. On 4/16/15 at 9:32 (LPN)-H stated the assisted R97 with r for placing R97's her consisted in her ears she would like to have ear and R97 sproceeded to place ear and R97 thanks. On 4/16/2015 at 10 (SS)-D stated her ewas getting resider hearing aids should	ve her bilateral hearing aids in R97's bilateral hearing aids en she comes to visit her. Is frequently during the week. a.m. R97 was observed to be ear in her room reading the ain her hearing aids had not a.m. licensed practical nurse nursing assistant who morning cares was responsible earing aids for the day. a.m. during an observation of did not have her hearing aids and then LPN-H asked R97 if ave her hearing aids placed in stated, "Yes." LPN-H and R97's hearing aids in each ed her. 2:03 a.m. social services expectation was when staff ints ready for the day their did be placed.				
	provided. SUGGESTED MET The director of nurs policies and procec plan was followed. inservice all staff to The director of nurs compliance.	THOD OF CORRECTION: sing could review and revise dures to ensure resident care The director of nursing could of follow the resident care plan. sing could monitor staff				
	TIME PERIOD FOR	R CORRECTION: Twenty-one				

Minnesota Department of Health

STATE FORM 6899 IBO111 If continuation sheet 4 of 71

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00360	B. WING		04/	16/2015
	PROVIDER OR SUPPLIER	TH CARE CENT! 610 SU	ADDRESS, CITY, IMMIT DRIVE ONT, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 4	2 565			
	(21) days.					
2 570	MN Rule 4658.0405 Plan of Care; Revis	5 Subp. 4 Comprehensive ion	2 570			5/14/15
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within	resident, the resident's lega representative at least seven days of the revision of resident assessment require	ds,			
	by: Based on interview, facility failed to revis residents (R41) who continence over thr Findings include: R41 was admitted taccording to the facilitation diagnoses that included the congestive heart fair malaise, fatigue, an R41's admission Mi 11/26/14 indicated in Brief Interview for M 15 and R41 require one staff member for R41 was occasional received a diuretic in	and document review, the se the care plan for 1 of 3 o had a decline in bladder ee month period of time. To the facility on 11/20/2014 cility admission records with uded but were not limited illure, end stage lung diseased spinal cord myelodysplasi inimum Data Set (MDS) date no cognitive impairment with Mental Status (BIMS) score of dextensive assistance from or toileting. The MDS indicated the incontinent of urine and medication. Indicate the care plan for 1 of 3 of	a. ed a f	Completed on 5/14/15		

Minnesota Department of Health STATE FORM

_	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00360	B. WING		04/1	16/2015
-	PROVIDER OR SUPPLIER	TH CARE CENTE 610 SUM	DRESS, CITY, S MIT DRIVE IT, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 570	included Lasix (diur (mg) by mouth twic R41's care plan init R41 was at risk for related to decrease and exposure to me incontinence. The cincontinence and dand read, "Residen occasionallyhas for urinary tract infeidentify the amount toileting. R41's significant chindicated R41 requistaff member for to toileting program, wurine, and used a dHowever, the facilit plan to reflect the inthat had been code MDS. A communication the Physician Orders for to refuse to get up owith family. States a she gets up. Reside then put call light on The physician responsable to the physician responsable	retic medication) 40 milligrams e per day. iated on 12/2/2014 indicated alterations in skin integrity d independence in mobility pisture from urinary care plan identified history of ecreased awareness to void t is incontinent of urine uterine prolapse and is at risk ection." The care plan failed to of assistance R41 required for lange MDS dated 12/31/14 fired extensive assist of one illeting, did not have a trial was frequently incontinent of	2 570			

Minnesota Department of Health

STATE FORM BO111 If continuation sheet 6 of 71

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00360	B. WING		04/1	/16/2015	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LAKEVIE	W METHODIST HEA	LTH CARE CENT! 610 SUMM FAIRMON	MIT DRIVE T, MN 5603	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 570	During an interview registered nurse (R not been updated for incontinence status A facility policy pert asked for and not possible states and proceed plan was revised as nursing could inservesident care plan a nursing could monit TIME PERIOD FOR (21) days.	oreath during toileting. on 4/16/2015, at 2:36 p.m. N)-E verified care plan had or R41 after decline in . aining to the care plan was	2 570			5/14/15	
2 900	Subp. 3. Pressure comprehensive res of nursing services development of a nursing services development of a nursing services development of a nursing services that: A. a resident who without pressure sores unle condition demonstrate authenticates, that B. a resident was received necessary.	sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home pres does not develop less the individual's clinical lates, and a physician they were unavoidable; and they has pressure sores by treatment and services to revent infection, and prevent	2 900			5/14/15	

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/IDENTIFICATION NUMB		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00360		B. WING		04/1	6/2015
	PROVIDER OR SUPPLIER	TH CARE CENTS	310 SUMN	DRESS, CITY, S MIT DRIVE T, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 7		2 900			
	by: Based on observati review, the facility for care and treatment assessment, prescueducation, for 1 of 3	ent is not met as evide on, interview and docu ailed to provide approp including comprehens ribed treatment, and re 3 residents (R21) revies sure ulcer. This resulted	ment riate ive sident wed		Completed on 5/14/15		
	Findings include:						
	assessment conductive current pressure arrisk for development Scale for Predicting conducted 12/30/14 as at high risk for pwith a score of 19 conducted 12/30/14, idebreakdown and curidentify any other provident Report data indicated staff had indicated ind	nentation of a body audited 12/16/14, R21 had eas to his heels, and what of pressure ulcers. A pressure Sore Risk had, and R21 had been id ressure ulcer development of 24. The Care Are regarding pressure ulcerified R21's risk for rent heel ulcers, but did ressure ulcers. A Resident 12/30/14 at 11:30 paidentified a reddened at a reddened a reddened at a reddened at the resident inic for evaluation of the physician's document of the physician's doc	d vas at Braden ad been lentified nent a cers d not dent .m., area on reas on erved visit had e areas ated l. Stage cuss instay of very				

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NAME OF PROVIDER OR SUPPLIER LAKEVIEW METHODIST HEALTH CARE CENTI (X4) ID PREFIX TAG PREFIX TAG COMPLET DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION :	(X3) DATE COMF	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 610 SUMMIT DRIVE FAIRMONT, MN 56031 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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				R WING			
LAKEVIEW METHODIST HEALTH CARE CENTI Complete the continued from page 8 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			00360	b. Wind		04/1	16/2015
CAMPUTED CAMPUTED	NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	LAKEVIE	EW METHODIST HEA	I IH CARE CENII		1		
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	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETE
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, and to help prevent further pressure ulcers, and to help prevent further pressure ulcers, and to help 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 [realdent] is at risk for pressure areas rt [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	She did become conthese particular issimples worse if she does rinstructions" R21 1/6/15, after she was pressure ulcer on the discharge summary readmitted to the fast of a wound vacuum stage IV pressure undeveloped the stage be hospitalized, the comprehensive reatissue after R21's redetermine what interpromote healing of help prevent furthed developing. An admission Minimal 12/19/14, identified required extensive bed mobility, had on ulcer (the outer layounderlying layer of as remaining at risk development. Add on the CAA for presindicated R21 had a heel, required a speand repositioning, a move. In addition, included: "Res [resareas r/t [related to tissue perfusion, hy radiation." The CA referrals but directed plan."	oncerned once I discussed that ues can get progressively not follow wound care is required hospitalization on as noted to have a stage IV he coccyx. The hospital y indicated she had been acility on 1/14/15, with the use in (VAC) system to treat the ulcer. Although R21 had ge IV pressure ulcer and had to a facility had not completed a assessment of the resident's return to the facility in order to erventions to implement to the pressure ulcers, and to impressure ulcers from the pressure ulcers from mum Data Set (MDS) dated if R21 as cognitively intact, assistance with transfers and the current stage II pressure er of skin and part of the skin is damaged or lost), and is for pressure ulcer ititional information documents sure ulcers dated 12/30/14, an "existing ulcer" on her left ecial mattress, regular turning and needed staff assistance to the CAA documentation ident] is at risk for pressure of overall health issues, poor in the complete of the	o d			

_	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION		E SURVEY PLETED
		00360	B. WING		04/	16/2015
	PROVIDER OR SUPPLIER	TH CARE CENTE 610 SUMI	DRESS, CITY, S MIT DRIVE IT, MN 56031	TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 900	further included: "F perfusion, often refi down during the da [wheelchair]. Often [reposition] when pr importance of reliev educated staff to do R21's Nurse's Note identified; "Residen buttocks wound. R sit too much and ac she should. Obser Purple area approx slightly open drainir flow sheet was filled and staff about its or relieving pressure w Will apply new cush to bed as interventi areas." When nursing assis about the pressure she stated, "It just is got here." NA-D als reposition every two However, during a s 4/15/15 at 10:54 a.r resistive to reposition admitted to the faci	Res. [resident] has poor tissue uses to lay [should be lie] y, prefers to sit up in w/c refuses to turn/repo rompted. Educated res. on ving pressure to bottom, ocument refusals consistently." It interviewed regarding esident states that she does dmits to not laying down when wed area [with] nurse and aide. imately 8 cm X 4 cm [with] a ng area at the top Wound dout and education to resident condition and importance of while up in chair and in bed. Inion to chair and air mattress ons to help relieve pressure stant (NA)-D was interviewed ulcer on 4/15/15 at 10:03 a.m. showed up, shortly after she so stated the staff help R21 or hours or as she requests. Subsequent interview on m., NA-D stated R21 had been oning since she had been	2 900			

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00360	B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKEVI	EW METHODIST HEAI	TH CARE CENTI	MIT DRIVE IT, MN 5603 [.]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	patient will also be wheelchair and at ti turning every 2 hou affected area. We a cushion that will horessure on this are indicated to "return weeks for repeat as issues develop beform the care. The note including on 1/6/15 for intravecare. The note including on 12/31, with coccyx. Apparently of skin surface was developed an ulcerpatient has developed ulceration with apparand a purulent male surrounding eryther discomfort associat patient has been vergarding-position." consult conducted hincluded: "Patient She has had radiati to assume that the compromised. Following R21's reading to a proper dated 1/18/15, iden cognitive impairment extensive assistance.	encouraged to stay out of her mes lying in her bed with rs to keep pressure off this will also see if we can get her help also prevent direct ea" The progress note also to clinic in approximately 3 seessment unless any acute ore hand." Ical (H&P) dated 1/6/15, been admitted to the hospital enous antibiotics and wound uded: "She was seen here in a reddened area on her on ulceration, her breakage noted at that timeshe has ation in the coccyx areaThe fed since 12/31, a deep coccyx arent probable undermining oddrous discharge. There is ma. There has been some fed with this. Apparently the ery difficult to a Consultation note from a coy a surgeon on 1/8/15, has a poor medical condition. Ion for her tumor and one has skin in this area is owing her surgery, the patient nome and developed an occyx which has gotten	2 900			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		SURVEY PLETED
		00360	B. WING		04/	16/2015
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
LAKEVI	EW METHODIST HEA	I IH CARE CENII	MMIT DRIVE ONT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
2 900	Continued From pa	age 11	2 900			
	along with one stag	ge IV pressure ulcer.				
	had fragile skin, a "admission", and "of lie] down, get off be prompt her to do so "Resident will have healed by next reviidentified intervention heels when in bed" & [and] cushion in treatments for L/he current orders - see	ated 1/28/15, identified R21 'heel ulcer present on ften refuses to lay [should be ottom thru the day when staff o." A goal was identified of, area on heel + [and] coccyx ew." Further, the care plan ons which included, "Float ', "Pressure reducing mattres w/c [wheelchair]", and "follow tel [left heel] + coccyx as per te 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 .			
	(RN)-E and RN-F v R21's pressure ulco routinely refused re admission however any education rega repositioned, until t RN-F also stated R comprehensively re risks when she'd re	old a.m. registered nurse were interviewed regarding er. They confirmed R21 had epositioning since her r, the facility had not complete ording risks of not being the breakdown on her coccyx R21 should have been eassessed for pressure ulcer eturned from the hospital. Gress note, dated 1/20/15, ient [R21] underwent a				

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Minneso	ta Department of He	ealth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00360	B. WING		04/1	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
LAKEVIE	EW METHODIST HEA	TH CARE CENTI	MIT DRIVE IT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900	ulcer [pressure ulcer Following this procedevice [uses medicate to create negative pressure ulcer which placed." A further \$2/5/15, identified Radecubitus ulcer locand, "The patient [Isurgery Clinic on Jawas noted to have unit, along with a succeygeal decubitual identified, "addition the wound specialishome." The dressi appointment, so the undermining. A sulnote, dated 3/23/15 the deepest along taspect of the wound or undermining not identified, "I [nurse contact nursing hor [LPN-B] in regards had been advised a [PT], to obtain a for wound as the foam filling the open wou Exchange Form, dahad been seen in the "coccyx ulcer", and identified, "Continuate pack deep into lease a series of the wound identified, "Continuate pack deep into lease a series of the wound identified, "Continuate pack deep into lease a series of the wound identified, "Continuate pack deep into lease a series of the wound identified, "Continuate pack deep into lease a series of the wound identified, "Continuate pack deep into lease a series of the wound identified, "Continuate pack deep into lease a series of the wound identified, "Continuate pack deep into lease a series of the wound identified, "Continuate pack deep into lease a series of the wound identified, "Continuate pack deep into lease a series of the wound identified, "Continuate pack deep into lease a series of the wound identified in the wound	ent of a coccyges decubitus er] on January 12, 2015. edure, a VAC wound care all foam and a small vacuum pressure on a wound or ch facilitates healing], was Surgery progress note, dated 21 was seen for "a stage 4 ated in her coccygeal area", R21] was last evaluated in anuary 27, 2015 when she an inadequately placed VAC mall sponge within the large sulcer." Further, the note all instructions were given to st at patient's [R21] nursing ng was not removed at the eulcer was not evaluated for osequent Surgery progress i, identified R21's ulcer "is at he left lateral and left inferior d", and, "No fistulas, tunneling ed." Further, the note practitioner (NP)-A] did me staff and talked with to the wound dressingthey approximate 2 weeks ago by am roping to place in the they have was not completely nd." A Medical Information ated 3/30/15, identified R21 ne clinic on 3/30/15 for a included a treatment which e [with] wound vac. Make sure eft deep aspect of wound." sidentified as "stable" by the	2 900	DEFICIENCY)		
	A review of R21's V the following inform	Vound Flowsheets identified pation:				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00360	B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, S	STATE, ZIP CODE		
LAKEVII	EW METHODIST HEAI	LTH CARE CENT! 610 SUMM FAIRMON	NIT DRIVE T, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900	On 4/2/15, the presom X 1 cm in size, treatment of, "Continu On 4/3/15, the presom X 0.8 cm in size to identify, "Continu On 4/8/15, the presom X 1.5 cm in size for staff to "Continu On 4/10/15, the presom X 1.5 cm in si "healing", and for si treatment." No undermining was for R21's pressure During observation 4/15/15 at 1:29 p.m type wound VAC dr IV pressure ulcer of was symmetrical in (beefy red tissue in approximately 50 proportion of the wound vac kit. RN the wound at 3 cm cm (depth). However, the foam down to the pressure ulcer's a new VAC Granufor the foam down to the and applied it into the ulcer. RN-D did no pack the foam into RN-D cut a new cleen.	sure ulcer measured 4 cm X 3 was "healing", and listed a nue current treatment." sure ulcer measured 4 cm X 3 e, was "healing", and continued e current treatment." sure ulcer measured 3 cm X 2 e, continued as "healing", and e current treatment." sure ulcer measured 4 cm X ze, remained identified as taff to, "Continue current s identified on the flow sheets	2 900			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		00360	B. WING		04/1	16/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	STATE, ZIP CODE		
I AKEVII	EW METHODIST HEAI	TH CARE CENTS 610 SUM	MIT DRIVE			
LAKEVII	-W METHODIST HEAT	FAIRMOI	NT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 14	2 900			
	attaches the dressing to the vacuum device.					
	observation of pres 1:43 p.m. RN-D sta pressure ulcer on 4 undermining at that piece of foam to be verified she did not undermining of the instructed in the proif she had any educapplication of the w she had no formal e system, only having dressings from, "W When R21 had the therapist (PT)-A had education on how to change; however R demonstration. Fur	mmediately after the sure ulcer care, on 4/15/15 at ted she last observed R21's /6/15 and it did not have any time. RN-D cut the new tter fit the wound today, but pack the foam into the wound as the physician had ogress notes. On asking RN-D cation on the use and ound VAC system she replied education on the wound VAC knowledge of the device and hat we learned in school." wound VAC placed, a physical dome and performed complete R21's dressing N-D was unable to attend the other, RN-D stated she sing change as she had been ses.				
	stated she had last month prior when F an appointment witl	4/15/15, at 2:50 p.m. PT-A seen the wound about a R21 had come to the clinic for h NP-A. The NP-A had written				
	follow regarding the including packing the	s for the nursing home staff to e pressure ulcer treatment, ne undermining and tunnels of e VAC foam. PT-A stated R21				
	had come into the c nursing home befor completed correctly	clinic (1/27/15) from the re with the dressing not r (in regards to the VAC wound				
	home and complete nurses on how to co	PT-A) had went to the nursing ed a demonstration for two omplete the pressure ulcer				
		sing the VAC foam and device. ere left with instructions to call				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00360		B. WING		04/1	6/2015	
	PROVIDER OR SUPPLIER EW METHODIST HEAI	TH CARE CENTE 610 SUM	DDRESS, CITY, S MIT DRIVE NT, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	her or KCI (the mar if they had question An interview was at 4/15/15, at 2:59 p.m the office for a period During interview on surgeon's nurse, LF regarding R21's stawas last seen on 3/ nursing home staff and place the foam aspect of the left intwound." When interviewed of stated she had never dressing herself, but pressure ulcer in lath had not gotten a cleat that R21's pressur packed with the VA underneath, to the but unaware what form completed for the schanges, but that stated the measure pressure ulcer at the documented on the likely not accurate exchanges were not ophysician, it could hulcer, "Possibly, year The director of nurse 4/16/15, and unavarent was at the state of the schanges were not ophysician, it could hulcer, "Possibly, year The director of nurse 4/16/15, and unavarent was at the state of the schanges were not ophysician, it could have the state of the schanges were not ophysician, it could have the state of the schanges were not ophysician, it could have the state of the schanges were not ophysician, it could have the state of the schanges were not ophysician, it could have the schanges were not ophysician.	nufacturer of the VAC system) is. tempted with the NP-A on in.; however she was, "out of od of time." 4/15/15, at 3:01 p.m. R21's PN-O was interviewed age IV pressure ulcer. R21 30/15 by NP-A and the was advised to pack the ulcer dressing "into the deepest ferior portion of the decubitus on 4/16/15, at 9:53 a.m. RN-E er changed R21's VAC at last observed R21's the March 2015 and at that time ear look at it. RN-E then added the ulcer undermining should be C foam, "To heal from pottom up." RN-E was all education had been taff regarding R21's dressing taff should be measuring the expest part. Further, RN-E ments collected of R21's e facility which were Wound Flowsheets were especially if the dressing completed as directed by the lave worsened R21's pressure				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATI COM							
00360			B. WING		04/1	16/2015				
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 610 SUMMIT DRIVE FAIRMONT, MN 56031									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE				
2 900	A facility Wound Caidentified a purpose transmission of mic care procedures." guidance for staff rerisks of failing to relassessment of a reulcers, or for follow wound care.	are policy, dated 4/30/14, e of, "To prevent or minimize croorganisms during wound The policy lacked any egarding when to explain the position timely, conduct sident's risk for pressure ing physician guidance for	2 900							
	The director of nurse policies and proceed comprehensive skiin pressure ulcer treat education provided inservice licensed a services. The direct staff compliance.	n care, skin assessments, tments, and risk and benefit. Director of nursing could staff to provide skin care stor of nursing could monitor. The director of nursing could report the audit results to								
0.010	(21) days.	R CORRECTION: Twenty-one				F/4 A/4 F				
2 910	Incontinence Subp. 5. Incontinent have a continuous management to recunnecessary use of comprehensive reshome must ensure A. a resident without an indwelling unless the resident that catheterization	nce. A nursing home must program of bowel and bladdeduce incontinence and the fatheters. Based on the ident assessment, a nursing that: ho enters a nursing home ag catheter is not catheterized so clinical condition indicates was necessary; and no is incontinent of bladder				5/14/15				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING	·		
		00360	B. WING		04/1	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY,	STATE, ZIP CODE		
LAKEVIE	EW METHODIST HEA	LIH CARE CENII	IMMIT DRIVE ONT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910	receives appropriat	age 17 se treatment and services to strict infections and to restore a ler function as possible.	2 910 s			
	by: Based on interview facility failed to com need for an individu following a decline	ent is not met as evidenced, and document review, the aprehensively reassess the palized toileting program in urinary continence for 1 or iewed for urinary incontinence.		Completed on 5/14/15		
	Findings include:					
	according to the facting diagnoses that include	to the facility on 11/20/2014 cility admission records with uded but were not limited ilure, end stage lung disease, and spinal cord	·,			
	11/26/14 indicated of Brief Interview for N 15 and R41 require one staff member for R41 did not have a	inimum Data Set (MDS) date no cognitive impairment with Mental Status (BIMS) score of extensive assistance from or toileting. The MDS indicated trial toileting program and winent of urine and received action.	a f ed			
		dministration record (MAR) retic medication) 40 milligran e per day.	ıs			
	R41 was prescribed	adder Evaluation indicated d a diuretic, had mixed a history of incontinence,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION		E SURVEY PLETED	
		00360	B. WING		04/	16/2015
	PROVIDER OR SUPPLIER EW METHODIST HEA	TH CARE CENTE 610 SUM	DDRESS, CITY, S MIT DRIVE IT, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 910	voiding pattern was had 2-6 incontinence stage 1 pressure ul void was diminished. R41's admission Bote Evaluation revealed "Probable candidate program." R41's care plan init R41 was at risk for related to decrease and exposure to move incontinence. The continence and do and read, "resident occasionallyhas for urinary tract infection indicated R41 requisites and an indiprogram. R41's significant chindicated R41 requisites from R41's incontinence. How the care plan to reflincontinence that he significant change is comprehensively reprogram in the presincontinence since 11/26/14. A communication face.	s upon rising and after meals, be episodes per week, had a cer, and perception of need to d. bwel and Bladder Needs d a score of 14 which indicated e for scheduled toileting iated on 12/2/2014 indicated alterations in skin integrity d independence in mobility				

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
00360			B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKEVII	EW METHODIST HEAI	TH CARE CENTI	MIT DRIVE IT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 910	facility's Physician (author was a registrontinues to refuse and visits with familibreath when she go in her pad then put immediately. The prommunication by a week trial for som R41's quarterly MD required extensive toileting, was alway not on a trial toileting. The corresponding Review dated 3/31/incont. [incontinent] of Bowel. At risk for R/t [related to] Urina Again the quarterly in bladder continent revisions to the con address this decline. During an interview registered nurse (R not been revised to for R41. Facility policy Bower revised on 4/29/14 on the resident's confacility will ensure the bladder incontinent treatment and servinormal bowel or blaunder PROCEDUF	Orders form dated 2/25/15 and ered nurse stated R41 to get up out of bed for meals by. States she gets short of ets up. Resident will also void call light on to be changed obysician responded to ordering a trial of Klonopin for ething to calm her down. S dated 3/25/15 indicated R41 assist of one staff member for s incontinent of urine, and was ag program. Bowel and Bladder Quarterly 15 read, "Resident remains of urine, but cont. [continent of UTI [urinary tract infection] ary incont. and diuretic use."				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00000			B. WING		04/16/2015	
NAME OF I	PROVIDER OR SUPPLIER	00360		STATE, ZIP CODE	04/1	6/2015	
		610 SUMN		STATE, ZIP GODE			
LAKEVIE	EW METHODIST HEAI	FAIRMON	T, MN 5603	1			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE	
2 910	Continued From pa	ge 20	2 910				
	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						
2 930	TIME PERIOD FOR CORRECTION: Twenty-one (21) days. 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.		2 930			5/14/15	
	This MN Requirem	ent is not met as evidenced					

AND DUAN OF CODDECTION IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
	00360		B. WING		04/1	6/2015	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKEVIE	W METHODIST HEA	LTH CARE CENTI	610 SUMN FAIRMON	MIT DRIVE T, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 930	review, the facility fichecked placement infusing medication resident (R57) obsequences during the survey. Findings include: R57's annual Minim 2/11/15, identified Freceived "51 perceived "51 perc	on, interview, and do ailed to ensure nursing of a gastrostomy tube and formula for 1 of erved to have a tube of medication admination a.m. registered nurse of medications and brough shed oral medication dia pair of non-sterile of hile R57 removed a complete hile R57 removed to R57 septimental pair of hile pair of	ng staff pe prior to 1 feeding dated ntact, and r total istration e (RN)-A ght into her e gloves in elear ng it on a ght over a rom), d down (CC) s he th the rior to RN-A he ple, and in to avity. the pe after	2 930	Completed on 5/14/15		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.					SURVEY LETED	
		7t. Boilebiiva.				
		00360	B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
LAKEVIE	EW METHODIST HEA	LTH CARE CENT! 610 SUMN FAIRMON	MIT DRIVE T, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 930	Continued From pa	ige 22	2 930			
2 930	When interviewed oregards to the feed not received any for feedings since bein having "what I got i in 2009. RN-A ider been noted to mess RN-A stated she shiplacement of R57's medication or form stomach." During interview on regards to R57's f was unaware of an the facility that was feeding tubes. Fur should have been oprior to infusing me A facility Enteral Nu 4/29/14, identified a "Verify tube placem formulabefore ad SUGGESTED MET The director of nursing of the provided appropriation of the provided appro	on 4/16/15, at 8:38 a.m. in ing tube, RN-A stated she had rmal education on tube ing hired at the facility, only in the hospital" for training back ntified that R57, at times, had is with her tubing. Further, hould have checked the is feeding tube prior to infusing ula "to make sure its in her at 4/16/15, at 9:48 a.m. in feeding tube, RN-E stated she is formal education offered by completed with nurses for ther, R57's feeding tube checked for correct placement edication or formula. Intritional Feeding policy, dated a procedure which included, itentbefore administering ministering medications" THOD OF CORRECTION: sing could review and revise dures to ensure nursing the gastrostomy tube care. The could inservice licensed staff at gastrostomy care. The could monitor staff	2 930			
	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					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED					
			A. BOILDING.							
00360		B. WING		04/1	6/2015					
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
LAKEVIE	EW METHODIST HEA	I I H (:ARF (:ENI)	MIT DRIVE IT, MN 5603	1						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE				
2 965	Continued From pa	ige 23	2 965							
2 965	MN Rule 4658.0600 -Nutritional Status	0 Subp. 2 Dietary Service	2 965			5/14/15				
	must ensure that a which supplies the determined by the cassessment. Subs	onal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food								
	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.			Completed on 5/14/15						
	Findings Include:									
	glasses of juice dur at 9:20 a.m. Reside does not eat breakt good. Again on 04 was observed to ea her lunch independ chop, 100% of her ounces of Ensure of	to eat her toast with two ring breakfast on 04/15/2015 ent said at this time she usually fast but said her toast tasted 1/15/2015 at 12:27 p.m. R97 at lently, ate 100% of her pork yogurt. 3/4 of yogurt. drank 4 clear, 10 ounces of milk, none tof potatoes and gravy about								
	3-4-15, identified di and depression. A l status (BIMS) score	nimum Data Set (MDS) dated agnoses of anxiety disorder orief interview for mental e of 5 indicated severe nt and needed assist of one								

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY PLETED		
00360		B. WING		04/	16/2015		
	PROVIDER OR SUPPLIER	LTH CARE CENTI	610 SUM	DRESS, CITY, S MIT DRIVE IT, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 965	staff member for set Review of R97's we follows: 12-11-14: 117 (first 12-24-14: 107 1-29-15: 106 R97 had an 11 lbs. and 12-24-14; this was and 12-24-14; this was also become a first the weight 129 lbs., Rewoodland Assisted plus edema in right RegularPortion si Interventions starte R97's registered die dated 12-8-14 read	etup help only for eatieghts was document weight taken at the favored was 8.62% weight loss therapy assessment weight 129 lbs., cent weight 116 lbs. a Living,Edema on a second was a second weight 116 lbs. A second wei	ed as acility) 12-11-14 ss. at dated Current at Admit; 2 s notels on a	2 965			
	was recently 116# [assisted living], car [pounds]. Note post common. IDWR [id [pounds]. Current Enote documentati which staff writes is intakes and weights approaches are ind weight > [greater th intake of 50% or be R97's intakes were 2014 to April 2015. was not consistent, documentation four month of March 20	pounds] at Woodland me to Lakeview at 12 top [operative] hip edeal weight range] 12 to MI [body mass index on of edema in her rist new for her. Will most to determine if nutricated. Will aim to hot an] 115 lbs. and encepter at her meals." reviewed from Dece Documentation of meand there was not and for meal intakes for mean intakes for meal inta	d A.L. 29# dema is 1-149 # k] 20.2 ght arm, onitor tion old her ourage mber eal intake				

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 610 SUMMIT DRIVE FAIRMONT, MN 56031 (K4) ID PREFIX TAG (SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
LAKEVIEW METHODIST HEALTH CARE CENTI (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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			00360	B. WING		04/	16/2015
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) 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 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			TH CARE CENTS 610 SU	MMIT DRIVE			
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	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETE
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.	2 965	were reviewed sinc documentation resinutritional supplement ime Kemps BID (two written on the top opage. Nursing was supplement was give of the supplement was give of the supplement was give of the supplement of February 2015 MAF on 2-17-15, R97 prothis time the nurses the ensure clear was document amount I R97's nutritional stadate 2-23-15 read, DX [Diagnosis]; left depression. No che Able to feed self. IE 121-149# [pounds] levels are low. Res Appetite is poor mon hungry." Goal date drink 75% of supple included, "Diet: refloor dining room. Foffer snack between 2-23-15) Enc. intak protein foods, 4 oz [three times a day] at am/pm, [morning supplement was ad 2-13-15. R97's registered die 12-13-15 read, "n [pounds] on 12-11-15.	e admission. There was no dent was to receive a ent until 2-12-2015. At that vice a day) with meals was if the medication administration of signing off when the ven or documenting how much was consumed by R97. The R was reviewed and indicated efferred Ensure clear and at a started to document when as given, however did not R97's consumed. Attus care plan with a revised "At risk for nutritional status hip FX [fracture], anxiety, wing or swallowing difficulty. WR [ideal body weight range Total protein and albumin [resident] has lost wt. [weightst meals; she says she is not d 2-23-15 read R97, "will ement." Interventions gular, Provide meals to 2nd Provide set up help as needed in meals (added to care plan e at meals, esp [especially] of [ounces] Ensure clear TID (BID [twice a day] with meds plant on the care plan on etician progress note dated ote her weight is down to 117 and the plant is down to 117 and the plant is down to 117 and plant is	on h]:]:			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
İ		00360	B. WING		04/1	6/2015
	PROVIDER OR SUPPLIER	TH CARE CENTE 610 SUMM	, ,	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 965	day with med [media R97's certified dieta note dated 1-12-15 Kemps BID [twice a pass." R97's registered die 2-23-15 read, "refer Was recently hospic cholelithiasis (gall sercommended by the between 0-50%. W [pounds] by late Depretty stable before [February]. Was 10 started on kemps be was ordered instead today about her apprever hungry and geto tell me she does mid-morning snack. R97's medical record documentation rever notified of R97's were RD when she requestlear 4 ounces three intake and weight loprovide any previous notification of R97's weight loss and state ater and agreed to basket to eat throug stated nursing was monitor meal intake and more continuation of R97's weight loss and stated nursing was monitor meal intake and more continuation of R97's weight loss and stated nursing was monitor meal intake and more continuation of R97's weight loss and stated nursing was monitor meal intake and more continuation of R97's weight loss and stated nursing was monitor meal intake and intake and more continuation of R97's weight loss and stated nursing was monitor meal intake and more continuation of R97's weight loss and stated nursing was monitor meal intake and weight loss and stated nursing was monitor meal intake and weight loss and stated nursing was monitor meal intake and weight loss and stated nursing was monitor meal intake and weight loss and stated nursing was monitor meal intake and weight loss and stated nursing was monitor meal intake and weight loss and stated nursing was more continuation.	ication] pass." ary manager (CDM) progress read, " will start 4 oz [ounces] a day] with meds [medication] etician progress note dated red to dietary for poor intake. Italized d/t [due to] acute stones)small frequent meals ne provider. Intake has been eight decreased to 107# Interpretation of the comber 2014. Had stayed her hospital stay in feb 8# [pounds] on 2-12-15was aut did not like it. Ensure clear d on 2-17-15Talked with R97 petite. She tells me she is lets full quickly. She continues in't want to eat breakfast or a	2 965			

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00360	B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKEVII	EW METHODIST HEA	LTH CARE CENT! 610 SUMM FAIRMON	MIT DRIVE T, MN 5603 [.]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (CROSS)	D BE	(X5) COMPLETE DATE
2 965	CDM stated the pronoticed a weight los and she would notif I know they didn't le loss, because I would heed to see the patresidents should be day and this is not given the sheat talked to the have him ensure rethis was a concern. have been times whand I don't see a	otocol was when a nurse as, they are to notify dietary by the RD. The CDM stated, "et me know about R97's weight ald have written it down on my have alerted the RD of the ient." The CDM stated as weighed weekly on their bath getting done. The CDM stated he director of nursing (DON) to esidents are being weighed as The CDM stated, "There hen I have looked at a chart eight for the whole month. It is a CDM stated, "There are so sument a weight, I think the shing them." The CDM again hould have informed dietary of and I know for a fact they did of the CDM stated the RD nutritional assessment, and as weights on a monthly basis. Here was no RD the month of January in the ec CDM stated she became ght loss in February after the	2 965			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	TE SURVEY MPLETED	
		00360	B. WING		04/1	6/2015
	PROVIDER OR SUPPLIER	TH CARE CENT! 610 SUMI	DRESS, CITY, S MIT DRIVE T, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	the first month of he On 4/15/15 3:46 p.r unable to find any of the physician regard 2-23-15, when the Inclear ensure 4 ound Review of the Weigread, "Purpose: To or lossProcedure on admission, week Periodic weight che residents with physianorexia, dehydrati whenever otherwise assistants should resheets. 6. Notify phweight loss or gain lost. 7. Consult with gains weight in excellents with physians weight in excellents. SUGGESTED MET director of nursing a can inservice staff of routritional meals prevent weight loss.	er stay in the facility. m. RN-F stated she was documentation of notification to ding R97 weight loss until RD requested an order for the ces three times a day. The cest three three three times a day. The cest three three three three three three times a day. The cest three	2 965			
21025	Potentially hazardor 40 degrees Fahren or below, or 150 de centigrade) or abov	5 Food Temperatures us food must be maintained at heit (four degrees centigrade) grees Fahrenheit (66 degrees re. "Potentially hazardous od subject to continuous time	21025			5/14/15

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	:	COMP	LETED
		00360	B. WING		04/1	6/2015
					1 04/1	0/2013
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKEVII	EW METHODIST HEA	LIH CARE CENII	MIT DRIVE IT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21025	Continued From pa	age 29	21025			
	and temperature corapid and progressi toxigenic microorga	ontrols in order to prevent the ive growth of infectious or				
	review, the facility, refrigerated food st and implement a portion food handling of left potential to effect 6 Findings included: During kitchen tour guided by the certification reveals cooler: 1 open bag approximately one CDM verified the datopping and stated During an interview answer to the queshandling leftover for there was more that would put in shallow refrigerator to be used the cooling paware of the process temperatures and the during an interview same question was stated leftovers were then placed in the cooling paware of the process temperatures and the cooling paware of the process temperatures and the cooling paware of the process temperatures and the placed in the cooling paware of the process temperatures and the placed in the cooling paware of the process temperatures and the placed in the cooling paware of the process temperatures and the placed in the cooling paware of the process temperatures and the placed in the cooling paware of the process temperatures and the placed in the cooling payare foods. C-A stated the potential process temperatures and the placed in the cooling payare foods. C-A stated the potential process temperatures and the placed in the cooling payare foods. C-A stated the potential process temperatures and the placed in the cooling payare foods. C-A stated the potential process temperatures and the placed in the cooling payare foods.	ion, interview, and document failed to ensure safe orage and failed to develop olicy and procedure for safe tover foods. This had the 3 out of 64 residents. on 4/13/15 at 3:10 p.m. ied dietary manager (CDM) ed the following in the reach in of whipped topping half gone dated 3/4/15. The ate on the bag of whipped it should have been discarded on 4/16/15, at 10:29 a.m. in tion "What is your process for ods?" the CDM explained if an 12 servings of leftovers they we pans and placed in the sed within the next few days. ey did not take temperatures orocess. The CDM was not dure to ensure safe imes for cooling left overs. If on 4/16/15 at 10:42 a.m. the sposed to cook (C)-A. C-A are placed in shallow pans and cooler. C-A stated they do not during the cooling process. explain the safe handling to illness for cooling leftover ne leftovers are then used for entrée at the next day's meal.		Completed on 5/14/15		

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
				A. BOILDING.			
		00360		B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKEVII	EW METHODIST HEA	LTH CARE CENTI		MIT DRIVE T, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21025	were not taken after further explained not temperatures had in On 4/16/15 at 10:45 was not a policy/proleftover foods other. Control (pertaining "Leftover foods will covered containers immediately in cool hot or protein food. under refrigeration hours, after which the Food temperature of January through Mareflect any second were obtained ever meal time. Facility policy Food which have opened an enclosed contained expiration dates on well as the refrigerar regular basis and for discarded." Facility policy Dishow "Dishes are to air of Dishes/glassware work contamination by ecovered in a dish low Facility policy Infecting the policy Infecting the policy of the covered in clean, dry SUGGESTED METTHE The registered diether policies and processerved at safe templements."	er reheated or recorder of recording those not ever been done. 5 a.m. the CDM stated occdure for safe hander than facility policy Information to dietary). This policy be placed in seamles and dated and dated and ler. Only 4 inches in diet. Only 4 inches in diet. Only 4 inches in diet. Only 5 inches in diet. Only 6 inches in diet. Only 6 inches in diet. Only 7 inches in diet. Only 8 inches in diet. Only 8 inches in diet. Only 9 inches in diet. Only 9 inches in diet. Only 1 inches in diet. Only 6 inches in diet. Only 6 inches in diet. Only 6 inches in	d there lling for fection / read, ss, nd stored epth if s placed ithin 72 rded" om lid not atures fered at ad, "Food laced in d. room as n a expired 2 read, se. ling unction, e ill be e." ION: d revise were ered	21025			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMF	SURVEY PLETED	
		00360	B. WING		04/	16/2015
	PROVIDER OR SUPPLIER	TH CARE CENTS 610 SUM	DDRESS, CITY, IMIT DRIVE NT, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21025	foods at safe tempe dietician could mon	ge 31 eratures. The registered itor staff compliance. R CORRECTION: Twenty-one	21025			
21134	MN RULE 4658.06 Sanitation, storage	70 Supb. 2. Dishwashing;	21134			5/14/15
	must be thoroughly surfaces of utensils given sanitization tr in such a manner a contamination. Cle	e. All utensils and equipment cleaned, and food-contact s and equipment must be eatment and must be stored s to be protected from aned and sanitized equipment be handled in a way that contamination.				
	by: Based on observati review, the facility, to refrigerated food stone sanitary dish storage implement a policy handling of leftover to effect 63 out of 6 Findings included: During kitchen tour guided by the certification reveals cooler: 1 open bage approximately one CDM verified the datopping and stated During the tour of the coolers of the course of the coolers	on 4/13/15 at 3:10 p.m. ied dietary manager (CDM) ed the following in the reach in		Completed on 5/14/15		

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Millinesc	ota Department of He	aim				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00360	B. WING		04/1	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	STATE, ZIP CODE		
TV WIL OF	THOUBERT ON COLT EIER		WIT DRIVE	5777 E, 211 GGBE		
LAKEVIE	EW METHODIST HEA	TH CARE CENT!	IT, MN 5603	1		
0//0 ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION		()(5)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
21134	Continued From pa	ge 32	21134			
	bowl dry storage rack revealed a stack of 4 bow					
	that were wet between the stacked bowls and 23					
	wet glasses that we	ere upside down and an entire				
		were stored upside down that				
	had condensation of	on the inside. The rack				
	contained a stack of	of wet glass bowls, when taken				
		ped to the side a small amount				
		t. 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					
		prior to putting them away.				
		e how long the dishes had				
	been stored on the					
		stored in a knife holder e of a preparation table. The				
		holder was not enclosed. The				
		nches off of the floor. A knife				
		the holder and found to be				
		gelatinized yellow debris as				
		. CDM verified knife was dirty.				
		on 4/16/15, at 10:29 a.m. in				
		tion "What is your process for				
	handling leftover fo	ods?" the CDM explained if				
		n 12 servings of leftovers they				
		v pans and placed in the				
		sed within the next few days.				
		ey did not take temperatures				
		process. The CDM was not				
	aware of the proced					
		imes for cooling left overs.				
		on 4/16/15 at 10:42 a.m. the				
		posed to cook (C)-A. C-A				
		re placed in shallow pans and				
		cooler. C-A stated they do not				
		during the cooling process.				
		explain the safe handling to illness for cooling leftover				
		ne leftovers are then used for				

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the second choice entrée at the next day 's meal.

Minnesc	<u>ita Department of He</u>	ealth	_			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
			D WING			
		00360	B. WING		04/1	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	STATE, ZIP CODE		
10 10 1	THO VIDEN ON OUT FIELD			517(12, 211 °COBE		
LAKEVIE	W METHODIST HEA	ITH CARE CENTI	MIT DRIVE			
		FAIRMON	IT, MN 5603	1		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIAIE	DATE
				BEITOLENOTY		
21134	Continued From pa	age 33	21134			
	•	-				
	C-A stated temperatures of second choice foods were not taken after reheated or recorded and					
	further explained no					
	temperatures had r					
	On 4/16/15 at 10:45	5 a.m. the CDM stated there				
	was not a policy/pro	ocedure for safe handling for				
	leftover foods other	r 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				
		ime they will be discarded"				
		ogs were reviewed from				
		arch 2015. The logs did not				
		choice entrée temperatures				
		n though they were offered at				
	meal time.	· and agriculty more concrete an				
		Storage (no date) read, "Food				
		d or prepared will be placed in				
		ner, dated, and labeled.				
		all foods in the storeroom as				
		ator will be checked on a				
		ood/fluids which have expired				
	discarded."	ocamaias willon have expired				
		washing signed 2/2012 read,				
		ry before storage or use.				
		will be protected from				
		nclosed storage or being				
	covered in a dish lo					
		tion Control (Dietary function,				
		ood Service and Ware				
		es, silverware, etc. Will be				
	stored in clean, dry	, and enclosed storage."				
	0110056555					
		THOD OF CORRECTION:				
		rtified Dietary Manager could				
	inservice all employ	yees responsible for storage of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00360	B. WING		04/1	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKEVIE	EW METHODIST HEAI	TH CARE CENTI	MIT DRIVE IT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21134	Continued From pa	ge 34	21134			
	dishes to store dish debris.	es that are dry and free from				
	TIME PERIOD FOF days.	R CORRECTION: Seven (7)				
21390	MN Rule 4658.0800	Subp. 4 A-I Infection Control	21390			5/14/15
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service exprevention and com E. a resident he immunization progradefined in part 465 procedures of resid the prevention and F. the development of the procedures of resident procedures, including defined in part 465 G. a system for H. a system for products which affed disinfectants, antised incontinence products.	ealth program including an am, a tuberculosis program as 8.0810, and policies and ent care practices to assist in treatment of infections; ment and implementation of olicies and infection control a tuberculosis program as 3.0815; reviewing antibiotic use; review and evaluation of ct infection control, such as eptics, gloves, and				
	This MN Requireme	ent is not met as evidenced				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED	
		00360	B. WING		04/1	04/16/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
LAKEVIE	EW METHODIST HEA	LIH CARE CENII	MIT DRIVE T, MN 5603	4			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
21390	review, the facility fand symptoms of p disease did not prowhich had potential residing on the secensure staff wore a equipment during a 2 residents (R35) or glucose checked did the facility failed to passed water to residents on the seable to drink water. Findings include: During observation licensed practical numbile medications for the second floor. LPN-stated she had a schead hurts." She his symptoms, including checked her temped degrees Fahrenheits she should not be verificated.	ion, interview, and document ailed to ensure staff with signs otentially communicable vide services for residents to affect 18 of 34 residents ond floor of the facility, and to ppropriate protective blood glucose check for 1 of bserved to have their blood uring the survey. In addition, ensure outside volunteers sidents using a sanitary potential to affect all of the cond and third floors who are	21390	Completed on 5/14/15			
	When interviewed oregistered nurse (R	on 4/15/15, at 7:34 a.m., IN)-D stated staff members ng if they are ill and/or have a ne policy."					
	4/15/15 at 7:37 a.m	bservation of LPN-I, on , she continued to prepare dents, despite identifying					

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
		00360	B. WING		04/1	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
LAKEVIE	W METHODIST HEAI	LIH CARE CENII	IIT DRIVE T, MN 5603 [:]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	.D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 36	21390			
	not wear any gloves medication prepara notify the director of when they arrive at stating, "I will talk to When interviewed of stated a staff member symptoms or fever resident population	fever and being ill. LPN-I did so or mask during the tion, and stated she would f nursing (DON) or scheduler the facility later in the morning to them." on 4/15/15, at 8:12 a.m. RN-F per who had nasal type should not be working with the and should be sent home ust kind of a common sense				
	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.					
	policy, dated 4/29/1 including, "To reduce infectious agents to frail resident or to condentified a procedule employee may report to the condentified approach to	Health Infection Control 4, identified a purpose the potential transmission of the physically or medically o-workers." Further, the policy are which included, "No ort to work with a feveror sease until you have been s."				
	LACK OF PROTEC GLUCOSE CHECK	CTION DURING BLOOD				
		on on 4/14/15, at 10:54 a.m. tical nurse (LPN)-H pierced				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			
		00360	B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKEVIE	EW METHODIST HEA	LIHCARECENII	MIT DRIVE IT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21390	Continued From pa	age 37	21390			
	which contains a ne blood) and squeeze hands exposing blo on the testing strip returned to the med	single use lancet (device eedle that is used to expose ed R35 's finger with her bare bod. LPN-H obtained a sample of the glucometer, and dication cart. LPN-H did not a during R35's blood glucose				
	LPN-H stated she s check R35's blood	on 4/14/15, at 10:55 a.m. should have worn gloves to glucose, but wanted to let R35 al, "Just hurry up and do it so				
	registered nurse (R trained to wear glov glucose monitoring	4/16/15, at 10:14 a.m. RN)-F stated all nurses are ves when performing blood for residents, and LPN-H oves on when checking R35's				
	4/29/14, identified a	cose Monitoring policy, dated a procedure which read, "Put es" prior to obtaining a blood				
	RESIDENTS: During an observat water pass perform from an outside age hygiene practices to cross contamination residents. On 4/15/15, at 9:27 entered resident roo of hand placed on t water cup; VOL-C h	rion of the third floor morning ned on 4/15/15 by volunteers ency, revealed a lack of hand o reduce the risk of possible n and spread of infection to a.m. Volunteer (VOL)-C om 355, palmed (entire palm top of lid to open) the lid of the hand touched the drinking area resident would put lips to sip				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY
				A. BUILDING:			
		00360		B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKEVII	EW METHODIST HEA	LTH CARE CENTI		MIT DRIVE T, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21390	water from cup. VC restroom sink, and placing the rim of the then put the lid on a the sink and the war of the room and hap almed the lid; VOL area on lid. VOL-A water cooler on a clid of the cup and to again. VOL-C stood and waited for cup to touch face, hair, un-wrapped a drink ends. VOL-A handed VOL-C placed the swater to room 355. On 4/15/15, at 9:34 room 310. VOL-D plid and removed the removed, VOL-D cwith her forefinger in VOL-D dumped the the bottom of the cosink, and then palm VOL-D then returned the room and have area. VOL-A then find the lid back on; tour lid. VOL-D returned the No observations we practicing safe han observations, the water foregree in volume and the volume area. Volume and the volume area was practicing safe han observations, the volume area was practicing safe han observations.	inge 38 DL-C carried the cup to tipped the cup upside the cup upside the cup on the bathroometer touching the outsider faucet, then carried the cup with ware art. VOL-A again touched the filled the cup with ware art. VOL-A then replay outside the drinking and on the other side of to be filled and was on and water cart. VOL-Ling straw and touched to be filled and water cart. VOL-Ling straw and touched the cup and replay to the cup and replay to the cup to the replay to the drain grate in the lid and put it is the cup to the drain grate in the lid; touched the water cup to the sand the water out of the water glass to roome are made of volunteed the drinking are not and the water out of the water glass to roome are made of volunteed the drinking are not and the water out of the water glass to roome are made of volunteed the water glass to roome are made of volunteed the water glass to roome are made of volunteed and the water cup to the water glass to roome are made of volunteed and the water cup to the water glass to roome are made of volunteed and the water cup to the water glass to roome are made of volunteed and the water cup to the water glass to roome are made of volunteed and the water cup to the water glass to roome are made of volunteed and the water cup to the water glass to roome are made of volunteed and the water cup to the lid; to th	e down om sink, side of ed it out DL-A ed drinking ter via aced the rea VOL-A observed C then ed both cup. The tresident up by the was restroom g onto it. It touched in the pack on. It is outside to VOL-A. It is outside to	21390			

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
		00360	B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	STATE, ZIP CODE		0,2010
		610 SUM	MIT DRIVE	577 L, 211 GODE		
LAKEVI	EW METHODIST HEAI	TH CARE CENTI	IT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 39	21390			
	During an interview registered nurse (R control stated expeduring water pass a been performed in a recommended infect stated volunteers worientation, which in stated she did not produced to volunteer what topics were control portion of or activities director properties director (A charge of the coord the outside agency orientation to the farm control portion. ADpassed water for the residents. AD-I state of orientation did coverified volunteers to receive domentation supervisor were supprovide oversight at The facility's Volunt dated 6/14/00 read, washing procedured A policy pertaining to requested and not result of the director of nurse policies and procedured control program wastaff. The director of staff to ensure an interview received only procedured control program wastaff. The director of staff to ensure an interview received only procedured control program wastaff. The director of staff to ensure an interview received only procedured control program wastaff. The director of staff to ensure an interview received nurse an interview received nurse received procedured and not received only procedured and not received and not recei	on 4/15/15, at 9:36 a.m. N)-F in charge of infection ctations of hand hygiene and the water pass had not accordance with ction control practices. RN-F were required to go through included infection control. RN-F provide orientation on infection is. RN-F was not aware of evered under the infection intentation. RN-F stated the evoluded orientation. on 4/15/15, at 9:39 a.m. ND)-I verified she had been in lination of the volunteers from and was responsible for cility that included the infection I explained, the volunteers in escond and third floor ed the infection control portion over hand hygiene. AD-I stated, the volunteer's posed to be trained as well to and guidance when needed. eer Orientation Checklist "Infection control (hand)."				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00360	B. WING		04/1	6/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKEVIE	EW METHODIST HEA	TH CARE CENTL	MIT DRIVE T, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21390	Continued From pa	ge 40	21390			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.					
21395	MN Rule 4658.0805 Persons Providing Services		21395			5/14/15
	volunteers, with a clisted in part 4605.7 lesions must not be nursing home unles person's condition without endangering residents and other policies required in item F, must addrespersons from work	ng services, including ommunicable disease as 7040 or with infected skin a permitted to work in the si it is determined that the will permit the person to work g the health and safety of staff. The employee health part 4658.0800, subpart 4, ss grounds for excluding and for reinstating persons to municable disease or infected				
	by: Based on observati review, the facility fand symptoms of p disease did not pro which had potential residing on the sec- Findings include: During observation	on, interview, and document ailed to ensure staff with signs otentially communicable vide services for residents to affect 18 of 34 residents and floor of the facility on 4/15/15, at 7:27 p.m. urse (LPN)-I was standing at a		Completed on 5/14/15		
	mobile medication of medications for the second floor. LPN-stated she had a so head hurts." She h	cart in the hallway preparing North and South wings of the I had audible congestion, and ore throat adding, "My whole ad developed these g a fever, on 4/14/15. LPN-I				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00360	B. WING		04/	16/2015
	PROVIDER OR SUPPLIER EW METHODIST HEAI	TH CARE CENT! 610 SUMI	DRESS, CITY, S MIT DRIVE IT, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21395	checked her tempe degrees Fahrenheit she should not be was ill, "If I have a fhere." When interviewed or registered nurse (Rare not to be working fever, "That's just the During continued of 4/15/15 at 7:37 a.m medication for resicherself as having a not wear any gloves medication prepara notify the director of when they arrive at stating, "I will talk to when interviewed of stated a staff membersymptoms or fever resident population, adding, "I think it's justing." During additional of 4/15/15 at 8:41 a.m administered a cup LPN-I did not have place to reduce the as she passed the into prepare and passed spite being identification in the proper in the	rature, and had a fever of 99.2 t (F). Further, LPN-I stated working with residents as she ever, I probably shouldn't be on 4/15/15, at 7:34 a.m., N)-D stated staff members if they are ill and/or have a ne policy." Deservation of LPN-I, on, she continued to prepare dents, despite identifying fever and being ill. LPN-I did is or mask during the tion, and stated she would finursing (DON) or scheduler the facility later in the morning	21395			
	A facility Employee	Health Infection Control				

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Minnesota Department of Health

-	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY DMPLETED	
		00360	B. WING		04/1	16/2015	
	PROVIDER OR SUPPLIER	TH CARE CENT! 610 SUMI	DRESS, CITY, S MIT DRIVE IT, MN 5603	STATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
21395	policy, dated 4/29/1 including, "To reduce infectious agents to frail resident or to concentrate a procedule employee may report other contagious distreated for 24 hours." SUGGESTED MET The director of nurse policies and procede working when ill. To inservice all staff to when ill. The direct staff compliance. TIME PERIOD FOR days.	4, identified a purpose the potential transmission of the physically or medically o-workers." Further, the policy are which included, "No ort to work with a feveror sease until you have been	21395			5/14/15	
21420	Prevention And Cor (a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volus Health shall provide regarding implements					5/14/15	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	<u></u>	COMPI	-E1ED
		00360	B. WING		04/1	6/2015
NAME OF		CTDEET AS	DDECC OITY	CTATE ZID CODE		
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKEVIE	EW METHODIST HEA	I TH CARE CENTI	MIT DRIVE	_		
		FAIRMON	IT, MN 5603			
(X4) ID		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
21426	Continued From pa	ugo 43	21426			
21420	Continued From pa	ige 43	21420			
	be maintained by the	ne nursing home.				
	This MNI Doguirom	ant is not mot as avidenced				
	-	ent is not met as evidenced				
	by:	and document review, the		Facility failed to do screenings on	5 of 5	
		ure screening for possible		newly admitted residents. TB test		
		mptoms with tuberculin skin		were not documented in millimeter		
		n completed for 5 of 5		induration. Facility failed to admin		
		4, R41, R95, R97) newly		second Mantoux on new resident		
		lity and failed to ensure		not give two step Mantoux on rece		
		with TST was evaluated		employees. Facility has changed		
		residents newly admitted to the		employee process by developing a		
		ensure tuberculosis testing		screen/immunization form that mu	st be	
	was completed for	2 of 5 employees (E-A and		completed with infection control		
	E-B) newly hired.			coordinator prior to direct care with		
				facility. New education material pr		
	Findings include:			to nursing staff on proper technique		
				reading and documenting results of		
		D RESIDENTS LACKED TST		Mantoux test. A screening from for	r new	
	REQUIREMENTS:			residents has been developed.		
	R21 had boon adm	itted to the facility on				
		ing to the face sheet.				
		IMUNIZATION RECORD for				
	<u> </u>	uberculin skin test (TST) on				
		2/18/14 the results were				
		ve however, lacked millimeters				
		The second step TST was				
		/28/14 and on 12/28/14 the				
		led as negative however the				
		ed mm of induration.				
		itted to the facility on				
		ng to their face sheet. R34				
	was administered t	he first step TST on 11/25/14				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00360	B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKEVIE	EW METHODIST HEA	TH CARE CENTI	MIT DRIVE T, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From page 44		21426			
	negative and not in evidence was locat R34 had received t	results were recorded as millimeters of induration. No ed in in the medical record he second step TST. itted to the facility on 11/20/14				
	according to her face records was review of having any TST	ce sheet. R41 's medical red and there was no indication test completed before or after ility was asked for TST				
	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.					
	according to the factorecords was review being completed. He a copy of form IMM provided and it had 12/5/14 and then led on 12/8/14 with reshowever, there was	itted to the facility on 12/5/14 ce sheet. R97 's medical ed and no indication of TST lowever, on asking the facility UNIZATION RECORD was the initial TST given on arned that they read the TST ults of "neg [negative]" is no documentation of how tion. Also there was no eted.				
		STING FOR NEWLY HIRED V HAD CONTACT WITH				
	results was given to This form had E-A employee, TB test of zero mm read by re	on 3/6/15. A form used for TB o surveyors which had no title. name, box checked for new dated 3/5/14, with results of egistered nurse on 3/6/15. nd TST completed for E-A.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					TE SURVEY MPLETED	
		00360	B. WING		04/1	6/2015
	PROVIDER OR SUPPLIER	TH CARE CENTE 610 SUM	DDRESS, CITY, S MIT DRIVE NT, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Nursing assistant (I first step PPD on 1/1 the employee file. Tadministered on 1/1 the employee's recorded form with TB results PPD was not found During an interview 1:00 p.m. the infect (RN)-F verified resurecorded, stated sy tuberculosis should residents, and state should have had se RN-F stated the fact pertaining to tubercused the Centers for guidelines and recorded guidelines and recorded tracking administration and how to appropriatel	NA)-G was administered the (5/15, no results were found in the second step PPD was (6/15, no results were found in ord. I on 3/10/15. The unnamed as Evidence of a second step in the employee's record. on 4/16/15, at approximately ion control registered nurse alts of TST were incorrectly imptom screens for active have been completed for ead employees and residents econd step TST administered. Edity did not have a policy ulosis screening; the facility or Disease Controls (CDC)				
21530	A. The drug regim reviewed at least m currently licensed b This review must be Appendix N of the S	O A.B.C Drug Regimen Review en of each resident must be onthly by a pharmacist y the Board of Pharmacy. e done in accordance with State Operations Manual, es for Pharmaceutical Service	21530			5/14/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00360	B. WING		04/1	6/2015
	PROVIDER OR SUPPLIER EW METHODIST HEA	TH CARE CENTE 610 SUM	DDRESS, CITY, MIT DRIVE	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	Requirements in Lot the Department of I Health Care Finance This standard is in available through the system. It is not sure B. The pharma irregularities to the and the attending properties to the and the attending properties. For purpon means the arreport and the signification of nursing services. C. If the attend with the pharmacist not provide adequate pharmacist believes being adversely after the matter to the attending physician. If the method attending physician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the matter to the matter to the matter to the attending physician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the matter than the attending physician does not must be referred for assessment and as by part 4658.0070. The medical direct must refer the matter than the attending physician does not must be referred for assessment and as by part 4658.0070.	ge 46 ong-Term Care, published by Health and Human Services, sing Administration, April 1992. Corporated by reference. It is ne Minitex interlibrary loan bject to frequent change. It is ne Minitex interlibrary loan bject to frequent change. It is ne Minitex interlibrary loan bject to frequent change. It is ne Minitex interlibrary loan bject to frequent change. It is new the proof the next proo	21530			
	review, the facility f pharmacist identifie	on, interview, and document ailed to ensure the consultant or irregularities for cation use and that the		Completed on 5/14/15		

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		` '	E CONSTRUCTION		SURVEY PLETED
712 . 2				A. BUILDING:			
		00360		B. WING		04/	16/2015
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
I VKE//I	EW METHODIST HEA	I TH CARE CENTS	610 SUM	MIT DRIVE			
LANLVI	LW INICITIODIST TICA	EIII CANL CLIVII	FAIRMON	T, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21530	Continued From pa	age 47		21530			
21000	physician follows up 5 residents (R83) remedications. Findings include: R83 was admitted according to the fac R83's facility Disea R83 was admitted that included but we with behavioral dist disorder. The diagracute exacerbation the diagnosis of pa 6/27/14. R83's quarterly Min 10/29/14 indicated and displayed behat others one to threassessment period assessed mood modicating moderate Signed physician or Risperdal (antipsycomouth once per da paranoia/agitation. 6/23/14 and was accorder was changed November 2014. The resident was not as extrapyramidal side Risperdal June 2014 assessed after the 2014. There was not behaviors identified was affective or no Signed physician or Depakote (mood stopy mouth once per depakote (mood stopy mouth once pe	p on recommendations eviewed for unnecessate to the facility on 5/23/2 cility's admission recorses Index Report reveto the facility with diagrere not limited to demeturbance and depressions of Schizophrenia was added on 5/30/14 ranoia agitation was an animum Data Set (MDS) severe cognitive imparational symptoms not deed and the MDS revealed a conitoring (PHQ-9) score depressive symptom reders dated 4/12/15 inchotic medication) 0.5 by for diagnoses of The original start dated diministered twice per date to 0.5 mg once per date to 0.5 mg once per date of the control of the Riemann of th	ary 2014 d. aled noses entia ve with 4 and dded on dated irment directed staff re of 10 s. cluded mg by was day; ay in that the tion of effects nber get sperdal cluded 250 mg date	21330			

Minnesota Department of Health

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Minnesc	<u>ota Department of He</u>	ealth				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
		00360	B. WING		04/1	6/2015
		00300			04/1	0/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE		
		610 SUM	MIT DRIVE			
LAKEVIE	EW METHODIST HEA	LTH CARE CENTI FAIRMON	IT, MN 5603	1		
(VA) ID	CLIMMADV CTA	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	NI.	(V5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
21530	Continued From pa	ngo 49	21530			
21330	Continued From pa	iye 46	21330			
	the Depakote since	the medication was started				
	on 7/30/14. There	was no resident specific target				
		d to determine if the medication				
	was affective or not	t.				
	Signed physician or	rders dated 4/12/15 included				
		pressant medication which is				
	used for insomnia)	50 milligrams (mg) by mouth				
		mg by mouth as needed if not				
		The start date of Trazodone				
		is needed order was added on				
	7/23/14. The pharm	nacist recommended reducing				
		5 mg 7/24/14 due to possible				
		dent falling. The Trazodone				
		this time and there was no				
	gradual dose taper	done since ordered on				
		ian 's justification as to why				
		pering was contraindicated at				
	this time.					
	Signed physician or	rders dated 4/12/15 included				
		ns (mg) every day for				
		iginal start date of Zoloft was				
		The physician had ordered				
		o 50 mg per day times one				
		then it returned to current dose				
	of 100 mg per day.	There was no gradual dose				
		d twice in the first year being				
		here a physician ' s justification				
	as to why it was con	ntraindicated to reduce the				
	Zoloft. A pharmacis	st note dated 8/8/14 included				
	"family has declined	d this med change" as a				
	reason a gradual de	ose taper was not attempted.				
		t an acceptable reason for not				
	attempting a dose r	reduction. Also the Zoloft				
		dent mood and/or behaviors to				
	monitor to determin	ne if the Zoloft was affective.				
	The only behavior r	monitoring tracking form that				
		medical record was from				
	March 2015 and ha	ad been used to monitor				
	depression. The tar	rget behaviors indicated were				
		s. The interventions that were				

STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00360	B. WING		04/1	6/2015	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
LAKEVIE	W METHODIST HEAI	LTH CARE CENT! 610 SUMM FAIRMON	IIT DRIVE T, MN 5603	1			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
21530	documentation reflerestless for the morn During an interview (RN)-E verified the target behaviors and had not been performed were not individually behaviors of restless monitoring for deprethere was no eviderany follow up with the medication regiment pharmacy recommend facility policy Pharmacy recommend facility policy Pharmacy recommended and the medications dose remonitor for beneficing adverse drug response. If and Indication distribution of the administered medication utilization with a summary of the administered medication utilization utilization of the consultant pharmacy medication utilization distribution of the consultant pharmacy of the consultant pharmacy medication utilization utilization of the consultant pharmacy of the consultant pharmacy medication utilization utilization of the consultant pharmacy of the consultant pharmacy medication utilization.	and not resident specific. The ected 1 episode of crying and on the of March. on 4/15/15 registered nurse facility had not developed dinterventions and monitoring red. RN-E verified there exed interventions for target issness and crying for mood ession. RN-E also verified ince in the medical record of the psychologist for possible in adjustment as a result of the endation on 2/13/15. Interventions for target issness and crying for mood ession. RN-E also verified ince in the medical record of the psychologist for possible in adjustment as a result of the endation on 2/13/15. Interventional services read, or the administered esponsenurses shall all therapeutic response, response, lack of resident enthly the nursing staff shall is observe dose-response of edications.", and "The cost shall monitor all aspects of edications.", and "The cost shall monitor all aspects of edications." THOD OF CORRECTION: THOD OF CORRECTION: The cost and director of nursing evise policies and procedures on irregularities were identified.	21530				
21540	MN Rule 4658.1319 Usage; Monitoring	5 Subp. 2 Unnecessary Drug	21540			5/14/15	

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PROVIDER OR SUPPLIER	00360	B. WING			
				04/16/2015	
W METHODIST HEAI	OTTLET ADI	DRESS, CITY, S	STATE, ZIP CODE	1 0-1/1	0/2010
	LTH CARE CENT! 610 SUMM FAIRMON	MIT DRIVE T, MN 5603	1		
(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
Subp. 2. Monitoring monitor each reside unnecessary drug	g. A nursing home must ent's drug regimen for usage, based on the nursing diprocedures, and the port any irregularity to the physician. If the attending concur with the nursing dation, or does not provide on, and the pharmacist nt's quality of life is being the pharmacist must refer the all director for review if the not the attending physician. If redetermines that the attending have adequate justification for attending physician does not the matter must be referred for y Assurance and Assessment equired by part 4658.0070. If ician is the medical director, macist shall refer the matter	21540			
Based on record re failed to identify targantipsychotic, mood psychoactive medic were affective. Also reduction/taper twic starting the medical justification as to will lack of monitoring a side effects was no 5 residents (R83) remedications.	get behaviors for the use and and behavior for use of cations to determine if they to attempt a gradual dose se within the first year of tion or a physician 's hy it was contraindicated. Also antipsychotic medication for t done. This was noted for 1 of		Completed on 5/14/15		
	Subp. 2. Monitoring monitor each reside unnecessary drug to home's policies and pharmacist must re resident's attending physician does not home's recommend adequate justification believes the resident adversely affected, matter to the medical director is the medical director is the medical director physician does not the order and if the change the order, the review to the Qualit (QAA) committee rethe attending physithe consulting pharmalized to identify targantipsychotic, mood psychoactive medical were affective. Also reduction/taper twice starting the medical justification as to what lack of monitoring a side effects was no 5 residents (R83) remedications. Findings include:	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:	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. 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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:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		00360	B. WING		04/	16/2015
NAME OF PROVIDER OR SUF	PLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
LAKEVIEW METHODIST	HEA	LIH CARE CENII	IMIT DRIVE NT, MN 5603	1		
PREFIX (EACH DEFI	CIENC,	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
R83's facility R83 was adm that included with behaviors disorder. The acute exacert the diagnosis 6/27/14. R83's quarter 10/29/14 indic and displayed at others one assessment passessed mo indicating more MDS also indone staff menthe exception assist of two signed physic Risperdal (and mouth once paranoia/agita 6/23/14 and worder was chance November 20 resident was extrapyramida Risperdal Junassessed afte 2014. There behaviors ide was affective Signed physic Depakote (mother by mouth once had been 7/30 regards to attribute of the signed physic Depakote (mother the signed	he facilities a little distribution of particular distribution of particular distribution of particular distribution of best affinities and side an	cility's admission record. ISSES Index Report revealed to the facility with diagnoses ere not limited to dementia turbance and depressive mosis of Schizophrenia with a was added on 5/30/14 and tranoia agitation was added on himum Data Set (MDS) dated severe cognitive impairment avioral symptoms not directed ree days during the I. The MDS revealed a staff conitoring (PHQ-9) score of 10 re depressive symptoms. The days required extensive of for activities of daily living with a mobility where R83 required exhotic medication) 0.5 mg by y for diagnoses of The original start date was administered twice per day; It to 0.5 mg once per day in here was no indication that the sessed for potential effects after the initiation of 14 nor was there side effects dose reduction November no resident specific target to determine if the Risperdal				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING.			
		00360	B. WING		04/1	6/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
LAKEVIE	EW METHODIST HEA	I IH CARE CENII	IMIT DRIVE NT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21540	on 7/30/14. There behaviors identified was affective or not Signed physician o Trazodone (antidegused for insomnia) before bed and 50 asleep in one hour. was 6/17/14. The a 7/23/14. The pharm the Trazodone to 2 side effects of reside as not reduced at gradual dose taper 6/17/14 or a physician of Zoloft 100 milligram depression. The or pre-hospitalization. Zoloft be reduced to week in July 2014 to f 100 mg per day. reduction attempted on Zoloft. A pharmacis "family has declined reason a gradual delawever, this is no attempting a dose of lacked specific resimonitor to determine	was no resident specific targe to determine if the medication to determine if the medication to the content of the medication to the content of the medication to the content of the conte				
	11/13/2014 identifice paranoid state and	h a last review date of ed R83 had severe dementia, depression. It alerted staff ctuated, had a lack of safety				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		00360		B. WING		04/	16/2015	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
I VKE//	EW METHODIST HEAI	TH CARE CENTS	610 SUM	MIT DRIVE				
LAKEVII	EW METHODIST HEAD	LITI CARE CENTI	FAIRMON	T, MN 5603	1			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
21540	Continued From pa	ge 53		21540				
	awareness and was identified target behrestlessness." The "mood and behavio in by NAR's [nursing shift." The care plarindividualized interv Trazodone. The car individualized targe the use of Risperda The only behavior mas evident in the march 2015 and had depression. The tar crying/restlessness listed were generic documentation reflerestless for the mor During an interview (RN)-E verified the target behaviors and had not been perform were not individuality behaviors of restless monitoring for depredictions dose monitoring for depredictions dose monitor for beneficial adverse drug respolack of therapeutic medications dose monitoring the response." and "Mochart a summary of the administered monsultant pharmace medication utilizations shall obtain the printindicating the reasourder. The goal of the summary of the goal of the goal of the summary of the goal of the goal of the summary of the goal o	s impulsive. The care naviors as "crying and care plan gave the dir monitoring sheets to assistant registered a lacked identification rentions for Zoloft and replan lacked any to behaviors or intervel and Depakote. In and Depakote and Depakote and been used to monitoring tracking for medical record was fred been used to monitoget behaviors indicated. The interventions the and not resident spected 1 episode of cryoth of March. On 4/15/15 registere facility had not developed interventions and not research and not resident spected interventions for session.	direction, o be filled dil every of of dil entions for orm that rom tor ted were eat were cific. The ying and dil nurse oped monitoring there target mood a read, all nse, iffects, ident ff shall inse of easpects of ng staff sis redication of therapy					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00360	B. WING		04/1	6/2015
	PROVIDER OR SUPPLIER	TH CARE CENTS 610 SUMM	DRESS, CITY, S MIT DRIVE T, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21540	will be listed on the on behavior monito shall define and list which shall be mon purpose of defining The attending phy psychoactive orders. This reevaluation structure is psychoactive dose outcomes and shall lowest effective cor SUGGESTED MET. The director of nursipolicies and proced psychoactive medicinursing could inserpsychoactive medicinursing could monitoric shall be supported by the structure of the	gress notes. This information pharmaceutical care plan and ring sheetsthe nursing staff targeted behavior symptoms, itored and counted for the psychoactive dose response vsicians shall reevaluate all at least every six months.	21540			
21620	MN Rule 4658.1345 Drugs used in the rin accordance with	ursing home must be labeled	21620			5/14/15
	by: Based on observati review, the facility fa labeling of medicati R14, R57) observed	ent is not met as evidenced on, interview, and document ailed to ensure accurate ons for 3 of 6 residents (R104, d to receive medication during f 5 residents (R10) reviewed edication use.		Completed on 5/14/15		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00360		B. WING		04/1	6/2015
	PROVIDER OR SUPPLIER EW METHODIST HEA	TH CARE CENTE 610 SUMM	DRESS, CITY, S MIT DRIVE T, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
21620	Findings include: R104's admission Mated 4/1/15, identiand received a daily Orders from Doctor an order of, "[change dosing to 2 units/15 with meals, per reside the polysical period on 4/14/15, at 11:25 (LPN)-H prepared imedication room or facility. The Novolothe surveyor and resurveyor an	Minimum Data Set (MDS), fied R104 had intact cognition, y insulin injection. R104's fax, dated 3/31/15, identified ge] Novolog rapid acting insulin is gram carb. [carbohydrates] ident." of medication administration a.m. licensed practical nurse nsulin for R104 in the nathese second floor of the ge insulin vial was provided to lad, "INJECT 1 UNITLY FOR EVERY 15 GRAMS MES DAILY." There was no label to alert staff to refer to a 3/31/15 physician orders. In the label prior to the dadministered it to R104. on 4/14/15, at 11:28 a.m. Idid not read the label prior to an for injection, "I'll be honest book at that." Further, the "label is would notify the pharmacy to a roder to reduce the risk of a S, dated 1/21/15, identified y intact. R14's Discharge and India set in the second intentified an set in the second intentified an intentified and set in the second intentified an intentified and set inten	21620			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00360	B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKEVII	EW METHODIST HEA	LIH CARE CENII	MIT DRIVE NT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21620	eye drops and provisurveyor which real EYES FOUR TIME DRY EYES." There label to alert staff to updated 11/15/14. The label and order label was not accur pharmacy. Further nurse is assigned to labeling, however staffing hours, it was completed. R57's annual MDS was cognitively into anti-anxiety medical Sheet, dated 4/7/15 [anti-anxiety medical sheet, dated 4/7/15 [anti-anxiety medical sheet] 1/2 [one hald Endoscopic Gastron During observation on 4/16/15, at 7:50 prepared R57's at a package was provisued TABLET VIA [by was the completed of the for use of half table regarding the label stated the label was had been faxing the changed for over a completed yet. Fur protocol is to get a	vided the container to the d, "INSTILL 1 DROP IN BOTH IS DAILY AS NEEDED FOR e was no modification to the prefer to the physician orders. When questioned regarding discrepancy, LPN-I stated the rate, and she would notify as becoming harder to get it as becoming harder to get it get a day]." I dated 2/11/15, identified R57 act, and took a daily ation. R57's Physician Orders of identified an order of, "Ativan ation] 0.5 mg [milligrams] tab late of medication administration a.m. registered nurse (RN)-A a mobile cart. The Ativan ded to the surveyor and read, van] TAB 0.5 MG TAKE 1 and of PEG TWICE DAILY." I dication to the label to alert physician orders dated 4/7/15 at of Ativan. When questioned and order discrepancy, RN-A inaccurate, and the facility e pharmacy in order to get it month, but it had not been rither, RN-A added, "Our new label."				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00360	B. WING		04/1	6/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKEVIE	EW METHODIST HEAI	LTH CARE CENT! 610 SUMN FAIRMON	MIT DRIVE T, MN 5603	1		
(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 SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21620	Continued From pa	ge 57	21620			
		he morning; inject 6 units noon." The insulin had a 2/15.				
	mellitus. R10's phy 2/10/15, revealed o seven (7) units at 8 p.m., and three (3) physician order for at 12:00 p.m. had a physician order for at 6:00 p.m. had a showever, the label six (6) units at 12:00	that included diabetes sician orders signed & dated rders for Humalog insulin :00 a.m., five (5) units at 12:00 units at 6:00 p.m. The Humalog insulin five (5) units a start date of 6/28/14. The Humalog insulin three (3) units start date of 2/11/14. for Humalog should have read 0 p.m. or noon. Also the label 6:00 p.m. dose of three (3) sulin.				
	administration reco	f the facility medication rd for 4/1/15 through 4/14/15, ved insulin as ordered.				
	physician dated 11/2 2/4/15, 2/25/15, 3/4	f blood sugar reports faxed to 20/14, 12/3/14, 1/28/15, /15, and 3/25/15, each ved Humalog insulin doses as				
	registered nurse (R dispense date of 4/3 directed Humalog 7 units at noon. Durin verified the insulin lat 6:00 p.m., as phy the label did not incorder for five units a	4/16/15, at 9:30 a.m., N)-E verified the insulin label 2/15 and that the label 2/15 and that the label 2/15 and that the label 3/10 units in the morning and 6/10 interview at that time, RN-E abel did not include three units a vician ordered. RN-E verified alude the current physician at 12:00 p.m. RN-E stated she notify the pharmacy when accepancies.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00360	B. WING		04/1	6/2015
	PROVIDER OR SUPPLIER	TH CARE CENTS 610 SUM	DRESS, CITY, S MIT DRIVE NT, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21620	When interviewed of dispensing pharmal medication labels is to the pharmacy so nursing staff should sticker on the label medication error undersonable in the pharmace 3/1999, identified, "periodically inspect of an accurate, currifor each resident." "Medication changed directions on the coal new label", and lise "Nurse removes the medication and crollarge black line or SUGGESTED MET The director of nurse review and revise pensure medication orders. The director of licensed staff to enslabels. The director compliance.	on 4/16/15, at 9:24 a.m. the cist (P)-A stated incorrect hould be immediately reported they can be corrected, and I place a "directions changed" to reduce the risk of till they can be changed. utical Services policy, dated Medication inventory shall be ed to insure the proper storage rent, non-expired drug supply Further, the policy added, e orders resulting in new ontainer label shall necessitate sted a procedure including, e respective container of sses the existing label with a				
21695		eration, & Maintenance	21695			5/14/15
	provide housekeep necessary to maint	eping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00360	B. WING		04/1	16/2015
					1 04/1	10/2013
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKEVIE	W METHODIST HEAI	TH CARE CENTI	IMIT DRIVE NT, MN 5603	1		
040.15	CLIMMADY CTA		-		ION!	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 59	21695			
	ceilings, registers, f and furnishings.	ixtures, equipment, lighting,				
	by: Based on observatireview, the facility facility facility facility facility facility facility. This had of 64 residents that Findings include: During the tour of the certified dietary at 3:10 p.m. The collayer of gray dust, thad an overall smeather that an overall smeather than the facility had a layer of substance and crurstainless steel below bottom of the ovens thick layer of dried in the ovens located had oven racks set underneath the racid debris and dust. The smeared with debris facility facil	ks the oven surfaces had dried e fronts of the ovens were	d	Completed on 5/14/15		
	legs, where the bov around the legs of t beater would be atta congealed fluid.	vl connects to the mixer, and he mixer. The area where the ached showed yellow				
	had dried food debr A long preparation tappliances including processor, a mixer cluttered and had for edge. The microwa					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00360	B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKEVIE	EW METHODIST HEA	LIH CARE CENII	MIT DRIVE IT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	where the beater w buildup of dark deb The floors underne preparation table (tand the dishwasher with debris. The mosurrounded the kitch buildup of debris. The mosurrounded the kitch buildup of debris to During a kitchen too (two days later) the were observed. During an interview CDM stated a clear expected staff to foexplained the mains washed the floors conce a week with a The facility cleaning staff to clean work a schedule did not give equipment in the "w cleaning and upkeed SUGGESTED MET The registered dieti director could revie procedures to ensu kitchen was maintar could inservice diet and sanitary kitcher could monitor staff	underside of the small mixer ould be attached showed a ris. ath the sink, the long able with small appliances), rarea were extremely soiled up boards or base boards that hen were soiled with a black he grouted areas of the tile seboards showed black o. ur on 4/16/15, at 10:30 a.m. same findings as outlined on 4/16/15, at 11:26 a.m. ning schedule is used and llow the schedule. CDM tenance department pressure once a month and sometimes floor machine. If schedule gave direction to area daily. The cleaning we details of surface areas or work area" that may need daily ep. THOD OF CORRECTION: cian and the housekeeping we and revise policies and the aclean and sanitary ined. The registered dietician ary staff to maintain a clean and the registered dietician ary staff to maintain a clean and the registered dietician	21695			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED						
			A. BUILDING	·							
		00360	B. WING		04/1	6/2015					
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
LAKEVI	EW METHODIST HEA	I I H (:ARF (:ENI)	MIT DRIVE NT, MN 5603	1							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE					
21805	Continued From pa	nge 61	21805								
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805			5/14/15					
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ect for their individuality by ersons providing service in a									
	by: Based on observation review, the facility for dining experience coroom for 4 of 4 resi	ent is not met as evidenced ion, interview and record ailed to provide a dignified on the 3rd floor west dining dents (R3, R83, R33 and R6) ogether during their dining		Completed on 5/14/15							
	Findings include:										
	eat their meal were on 4/13/15 at 5:07 pand 4/16/15 at 11:4 floor west dining rothe "feeder dining the tables in this diplacemats or table 's food was left on residents were assindependent dining placemats on the tameals were delivered.	R6 all dependent on staff to observed during observations p.m., on 4/14/15 at 9:05 a.m. 5 p.m. located on the third om also referred to by staff as room." It was observed that ning area did not have center pieces and the resident the serving trays while isted to eat. However, the room had fresh flowers and ables also the resident's ed to the residents on serving was removed from the serving									
	nursing assistant (N	on 4/13/15, at 5:11 p.m. when NA)-E donned a clothing A-E did not give R3 the choice									

AND BLAN OF CODDECTION IDENTIFICATION AND DED		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00360		B. WING		04/16/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
LAKEVIE	EW METHODIST HEA	TH CARE CENTI	MIT DRIVE T, MN 5603 [.]	1		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 62	21805			
		othing protector on and NA-E ne clothing protector was going				
	placed a meal serv NA-E did not uncov and left the room. F silverware off of the	on 4/13/15; at 5:15 p.m. NA-E ing tray off to the side of R83. For the meal for the resident R83 then attempted to grab the e tray. At 5:17 NA-E returned, I, cut up the sandwich, and left ain.				
	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.					
	placed meal tray in sleeping since the state then uncovered the pureed cold ham sa carrots, and pureed NA-F walked away attempt to awake F to arouse R6 was mattempt to awake F food had remained NA-F did not take the prior to assisting R6	front of R6 who was still start of meal service. NA-F food tray that contained andwich, pureed cooked mashed potatoes. Then from the table. NA-F did not see the second of				
	service NA-E and N dining room at the s assist four resident NA that was left in t	jority of the 4/13/15 dinner JA-F were not present in the same time; this left one NA to s at two different tables. The he dining room alone moved sident and table to table, gave				

AND DUAN OF CODDECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00360	B. WING		04/	16/2015
NAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE		
LAKEVII	EW METHODIST HEAI	TH CARE CENTI	NT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21805	a few bites to all resother. NAs were obto stand next to the with eating. NAs did between residents a wheelchairs, and w During an interview referred to the west dining room. "NArequired assistance that dining room on During an interview registered nurse (Rwas referred to as t stated residents coron the first floor, stacommunicate prefereder dining room not aware if the me removed from the explained NAs suppost between residents amy be contaminated received education and recei	sidents within minutes of each served on several occasions resident when assisting them don't wash/sanitize hands after touching tables, iping faces off. on 4/13/15, at 5:11 p.m. NA-Exidining room as the "feeder Explained residents that with eating were assigned to admission to the facility. on 4/16/15 at 10:04 a.m. N)-F stated the dining room the "feeder dining room", and deat in the main dining room at the deat in the main dining room at the graph of the "" on admission. RN-F was all was supposed to be serving tray or not. RN-F toosed to wash/sanitize hands and touching surfaces that the death of the explaining to hand washing atton routinely. on 4/16/15, at 10:21 a.m. nager (CDM) verified the west 3rd floor was referred to as room." CDM stated, "We in that dining room on stated, "The meals go up on the disassembling the trays and exident." CDM stated, "We atts down [in reference to 3rd"				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00360		B. WING		04/1	16/2015
	PROVIDER OR SUPPLIER	TH CARE CENTS 61	10 SUMN	ORESS, CITY, S MIT DRIVE T, MN 5603	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21805	Difficulties date last Residents who eat must eat independe aspiration." Facility policy East Aide Responsibilities instructed staff to "prompt, dignified m prevent spread of in at a table before se resident requires as beside him/her whill never leave dining in SUGGESTED MET. The director of nursipolicies and proceed dining experience woursing could monit staff provided dining manner. The direct all staff to provide a director of nursing could monit staff to provide a director of nursing could in the director of nursing	ge 64 I revised 4/30/14 read, in the 1st floor dining roently and are not at risk. Dining Room Hostess/Nes last reviewed 4/29/15 provide residents with eal service, wash hands offection, serve all reserving the next table, asist with eating, sit down e assisting, arrange trayroom unattended " CHOD OF CORRECTION in the direction of the dining room to end to the dining room to end to the dining service and results of the corted to the quality assurance or designee could conductor the dining service and results of the corted to the quality assurance in the service and results of the corted to the quality assurance in the service and results of the corted to the quality assurance in the service and results of the corted to the quality assurance in the service and results of the corted to the quality assurance in the service and results of the corted to the quality assurance in the service and results of the corted to the quality assurance in the service and results of the corted to the quality assurance in the service and results of the corted to the quality assurance in the service and results of the corted to the quality assurance in the service and results of the corted to the quality assurance in the service and results of the corted to the quality assurance in the service and results of the corted to the service and results of the corted to the service and results of the corted to the quality assurance in the service and results of the service and results of the corted to the service and results of the service and resul	om for Jurse s, sidents if a n y, N: evise ed ctor of nsure ervice e. The uct e	21805			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twen	ty-one				
21880	Residents of HC Fa Subd. 20. Grievar shall be encourage their stay in a facilit	ac.Bill of Rights nces. Patients and resident and assisted, through yor their course of treat exercise their rights as	dents out	21880			5/14/15

AND BLAN OF CORRECTION TO TRENTIFICATION NUMBER:).	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY LETED	
		00360	В	3. WING		04/1	6/2015
	PROVIDER OR SUPPLIER	TH CARE CENTS 610	SUMMIT		TATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21880	patients, residents, residents may voice changes in policies and others of their interference, coerci including threat of grievance procedur well as addresses a Office of Health Fanursing home ombound Americans Act, see posted in a conspice Every acute care residential program 253C.01, every nor facility employing more provides outpatient have a written interest a minimum, sets followed; specifies a limits for facility resor resident to have advocate; requires grievances; and program 253C.01 which are treatment programs centers with section health maintenance 62D.11 is deemed to conservations.	and citizens. Patients are grievances and recommand services to facility stance, free from restraint on, discrimination, or repulischarge. Notice of the e of the facility or programment telephone numbers for citity Complaints and the cudsman pursuant to the Cotion 307(a)(12) shall be	nd nend aff nt, risal, m, as or the area Dider very hall that, atient atient s, e by on	21880			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X) A. BUILDING:			(X3) DATE SURVEY COMPLETED						
		00360	B. WING		04/1	6/2015					
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
LAKEVIE	EW METHODIST HEA	I I H C:ARE C:EN II	MIT DRIVE IT, MN 5603	1							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE					
21880	This MN Requirements: Based on observation review, the facility of grievances were accomply the facility of grievances were accomply to the facility staff. Findings include: R13's quarterly Min 1/7/15, identified Rindle During an observation at 6:16 p.m. R13 staff. During an observation at 6:16 p.m. R13 staff. The facility, because a rooftop with heatification facility, because a rooftop with heatification for the facility of the facility	ent is not met as evidenced ion, interview, and document ailed to ensure unresolved ited on for 2 of 2 residents ied who had voiced concerns f. simum Data Set (MDS), dated 13 had intact cognition. ion and interview on 4/13/15, ated she had asked to be it room since she admitted to be her current room overlooked ing and cooling equipment. I'l keep the curtains closed, thing to see." R13's curtains ecured together with a wooden he interview. When curtains utside view included several is, and heating/cooling		Completed on 5/14/15							
	declined to move. R13's Social Service 8/5/14, read, "res room with a view he	t room months ago, but ses Progress Note, dated ident stated she would like a ere at Lakeview." Further, wed a room on West wing, 3rd									

Minnesota Department of Health

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AND DUAN OF CODDECTION IDENTIFICATION AND DED		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00360		B. WING		04/1	6/2015
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 0 1	0,=0.10
LAKEVIE	EW METHODIST HEA	TH CARE CENTI	MIT DRIVE T, MN 5603 [.]	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21880	Continued From pa	ge 67	21880			
	please resident. Re looking at a roof. F	tyle of room and view would esident stated she was still desident was informed she d as rooms became				
	p.m. LSW-A stated more rooms since soluting the day. R13 assisted living, but show her another roif a resident had a solution.	nt interview on 4/16/15, at 2:58 she had not shown R13 any 8/25/14, as R13 often naps 3 was on the waiting list for added, "I supposed I could com." Further, LSW-A stated concern with their room it d "most of the time", and, "I e in that room."				
	identified, "It is our grievances in a time hours (Monday thro concern or grievand	policy, dated 9/8/10, policy to address concerns of ely manner", and, "Within 48 ough Friday) of receiving the ce, the resident or family tracted regarding follow up."				
	3/4/15 indicated R9	imum Data Set (MDS) dated 7's ability to hear was use of a hearing aid.				
	hearing is adequate [bilateral] aides." In place hearing aids on nurse was to check	ted 03/15/13, read, to communicate needs ate with the use of bilat an addition it directed staff to daily in the morning and the to ensure they were and batteries were working.				
	R97 and her friend observed to not hav place. FR-A stated	p.m. during an interview with (FR)-A present, R97 was we her bilateral hearing aids in R97's bilateral hearing aids en she comes to visit her.				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00360	B. WING		04/16/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		610 SUMM	IIT DRIVE	····· =, =:		
LAKEVIE	EW METHODIST HEA	LTH CARE CENT! FAIRMON	T, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21880	Continued From pa	ge 68	21880			
	FR-A stated she ha facility staff on mult proceeded to assis aids and told surve	Indicate the standard shared this concern with the siple occasions. FR-A to the standard share the standard				
	sitting in her recline	a.m. R97 was observed to be in her room reading the hearing aides had not been				
	(LPN)-H stated the assisted R97 with n for placing R97's he stated she was una	a.m. licensed practical nurse nursing assistant who norning cares was responsible earing aids for the day. LPN-H tware R97's hearing aids not 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.					
	(SS)-D stated FR-A regarding R97's her SS-D stated she could the nursing department meeting for follow-unaids were being plasmas no further societhis concern. SS-D when staff was gett their hearing aids soconcerns are made and stated she would she would she would stated she would s	2:03 a.m. social services A had voiced a concern to her aring aids not being placed. Emmunicated this concern to ment at a morning stand up up to ensure R97's hearing uced daily. SS-D stated there al service follow-up regarding stated her expectation was sting residents ready for the day hould be placed. SS-D stated into grievances right away ald check her file to see if a regarding the concerns with				

Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		A. BUILDING	:			
		00360	B. WING		04/1	6/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
LAKEVII	EW METHODIST HEAI	LIH CARE CENII	MMIT DRIVE NT, MN 5603	1		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21880	should have been finearing aids not be On 4/16/15 at 11:23 unable to find a gridhearing aids not be depending on what whether or not she concern/grievance hearings aides wou could have easily fowere placed and thin not completed for the The grievances policed, "When a commember's attentional taken. 1. Complete the fact as much detail as p. 2. Immediately rout appropriate departments departments. 3. Within 24 hours original should be roused in the follow office with the follow office with the follow for the grievance. 5. Based on the condepartments will make resident or the family member. 6. Within 48 hours or receiving the concerning aids not be concerning the concerning and what the resident or the family member.	SS-D stated a grievance iled regarding the concern en placed. B a.m. SS-D stated she was evance form regarding R97's ing placed. SS-D stated the concerns was, determine would initiate a form. SS-D stated the ild have been an issue nursing bllowed up on to ensure they is was why a grievance was his concern. icy and procedure dated 2010 neern is brought to a staff in the following steps will be cility's grievance form: provide	y 1	DELITORING!)		

AND DUAN OF CODDECTION IDENTIFICATION NUMBER.			LE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED					
		00360	B. WING		04/	16/2015				
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 610 SUMMIT DRIVE									
LAKEVIE	W WETHODIST HEAD	FAIRMOI	NT, MN 5603	1						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE				
21880	Continued From pa	ge 70	21880							
	The director of nursing policies and proced family grievances wanner. The direct staff on the policies of nursing could more	THOD OF CORRECTION: sing could review and revise lures to ensure resident and vere addressed in a timely or of nursing could educate all and procedures. The director onitor staff compliance. R CORRECTION: Twenty-one								