Electronically Submitted
December 9, 2020

Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, MN 55063

RE: CCN: 245374
Cycle Start Date: November 16, 2020

Dear Administrator:

On November 16, 2020, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On November 13, 2020, the situation of immediate jeopardy to potential health and safety cited at F880 was removed. However, continued non-compliance remains at the lower scope and severity of F.

Also, on November 16, 2020, the situation of immediate jeopardy to potential health and safety cited at F886 was removed. However, continued non-compliance remains at the lower scope and severity of E.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 24, 2020.

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 24, 2020 (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 24, 2020, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 24, 2020,. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151

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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

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 May 16, 2021 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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.

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted from 11/9/20, through 11/16/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations §483.73(b)(6). The facility was IN full compliance Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted from 11/9/20, though 11/16/20, at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was determined NOT to be in compliance. The survey resulted in findings of immediate jeopardy (IJ), at F880, when it was determined the facility reused, shared, and improperly stored used isolation gowns. It was also determined the facility allowed employees, who had active COVID-19 infections, to enter the facility and work. The director of nursing (DON), assistant director of nursing (ADON), and registered nurse (RN)-A were notified of the IJ, at 5:50 p.m. on 11/10/20. The IJ was removed on 11/13/20, at 3:48 p.m., however, noncompliance remained at the lower scope and severity level of F, widespread, which indicated no actual harm with potential for more than minimal harm that is not	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/17/2020

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 IJ. An additional IJ, at F886, was identified when it was determined the facility failed to perform COVID-19 outbreak testing for all active staff. The DON, ADON, and RN-A were notified of the IJ, at 4:35 p.m., on 11/13/20. The IJ was removed on 10/16/20, at 3:18 p.m., but noncompliance remained at the lower scope and severity level of E, pattern which indicated no actual harm with potential for more than minimal harm that is not IJ. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 880 SS=L	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		1/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2	F 880		

and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement COVID-19 infection control practices related to the proper utilization of personal protective equipment (PPE) for residents whom had an actual or suspected COVID-19 infection. In addition, the facility failed to ensure staff who had COVID-19 were restricted from entering the facility and working, in order to minimize or contain the spread of COVID-19. These practices resulted in an immediate jeopardy (IJ) situation which had the potential to affect 5 of 26 residents (R1, R3, R5, R9, and R11) who resided at the facility and were not infected with COVID-19 and did not have a previous COVID-19 diagnosis. In addition, the facility failed to develop and implement a comprehensive infection prevention and control program (IPCP) to include surveillance of employee infections. This had the potential to affect all 26 residents who resided at the facility. The IJ began on 11/10/20, when it was determined the facility was reusing a variety of	F 880	Lakeside Medical Center updated PPE use procedures regarding isolation gown use. Gowns will not be hung or reused after removal by staff. A resident is suspected to have COVID but has negative test results: a new isolation gown will be donned every time staff enters the resident room. COVID positive residents: gowns may be worn between residents unless: " A resident has a secondary infection that requires any type of isolation. Staff will discard the isolation gown after each use in that room. " When gown becomes visibly soiled, staff must discard and don a new clean isolation gown.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4 isolation gowns (washable and disposable) for the duration of a shift, and lacked a mechanism for staff to determine which isolation gown they had worn. This resulted in staff sharing isolation gowns. It was further determined the facility had several mechanisms to store used isolation gowns which included hanging isolation gowns on hooks and/or other structures inside of resident rooms, and hanging isolation gowns on hooks in facility hallways. It was also determined the facility allowed employees who were COVID-19 positive, to care for residents who were not infected with COVID-19 and did not have a previous COVID-19 diagnosis. The director of nursing (DON), assistant director of nursing (ADON), and registered nurse (RN)-A were notified of the IJ at 5:50 p.m. on 11/10/20. The IJ was removed at 3:48 p.m. on 11/13/20, but noncompliance remained at the lower scope and severity level of F, widespread which indicated no actual harm with potential for more than minimal harm that is not IJ. Findings include: ISOLATION GOWNS R1's laboratory reports dated 11/2/20, 11/5/20, and 11/10/20, indicated R1 was negative for COVID-19. R2's laboratory reports indicated R2 tested positive for COVID-19 on 11/5/20. R3's laboratory reports dated 11/2/20, 11/5/20, 11/10/20, and 11/13/20, indicated R3 was negative for COVID-19. R4's laboratory reports dated 11/2/20, and	F 880	" Any time that staff member leaves the floor for breaks or other reasons, that gown is to be discarded. The residents identified as at risk for this citation would be the residents that do not have a COVID 19 history. There are currently 6 residents at risk for this citation. All COVID 19 positive staff who have not met the established return to work criteria were removed from the schedule on 11/12/20. Any staff member who has COVID-19 symptoms or a positive test will not be able to return to work until they meet criteria outlined in the COVID-19 Recommendations for Health Care Workers guidance from MDH. Staff were verbally trained, and printed education was issued on 11/16/20 on the accepted Removal Plans for Immediate Jeopardy. Ongoing training for employees will be completed by the infection control consultant, infection preventionist, director of nursing or designee. Observational audits will be conducted on PPE gown use 5x per week for 4 weeks, then weekly x 1 for 4 weeks, then monthly x3 months and quarterly thereafter; or until 100% compliance is achieved.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5 11/6/20, indicated R4 tested negative for COVID-19. R4 subsequently tested positive for COVID-19 on 11/10/20. R5's laboratory report dated 11/5/20, indicated R5 was negative for COVID-19. An undated document provided by the facility, indicated R5's subsequent COVID-19 test was "spilled" and unable to be performed on 11/9/20. R9's laboratory reports dated 11/2/20, 11/5/20, and 11/10/20, indicated R9 was negative for COVID-19. R11's laboratory reports dated 11/5/20, and 11/10/20, indicated R11 was negative for COVID-19. R13's laboratory report dated 11/5/20, indicated R13 was positive for COVID-19. R14's laboratory report dated 11/5/20, indicated R14 was positive for COVID-19. R15's laboratory report dated 11/6/20, indicated R15 was positive for COVID-19. R16's laboratory report dated 11/5/20, indicated R16 was positive for COVID-19. R17's laboratory report dated 11/2/20, indicated R17 was positive for COVID-19. R18's laboratory report dated 11/5/20, indicated R18 was positive for COVID-19. On 11/9/20, at 12:56 p.m. nursing assistant (NA)-A was observed entering R1's room and grabbed a patient gown (type of gown worn by	F 880	All employee COVID screening forms will be reviewed daily for 1 week, then 5 staff daily x4 weeks, then 5 staff weekly x1 month and then 1 staff quarterly or until 100% compliance is achieved. DON, IP or designee are responsible for compliance and these audits will be reviewed at the QAPI meetings. Compliance will be achieved by 1/15/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6	F 880		

hospitalized patients), which was laying on a footboard of an unoccupied bed. Signage on R1's door indicated he was "Negative." One patient gown remained on the footboard of the unoccupied bed. The two patient gowns were in direct contact with each other prior to NA-A removing one. NA-A put on the patient gown, approached R1 and told him she needed to take his weight. NA-A wheeled R1 outside of the room entry and subsequently removed the patient gown and laid it on the footboard of the unoccupied bed. NA-A wheeled R1 to a room, near the nurses' station, and obtained R1's weight. NA-A then wheeled R1 to his room and put on a patient gown which was laying on the footboard of the unoccupied bed. NA-A wheeled R1 towards his bed, returned to the room entry, and wheeled in a mechanical lift. NA-A requested NA-B, who was in the hallway, to assist transfer R1. NA-B responded she would be back. NA-A connected R1's lift sling to the mechanical lift and waited.

On 11/9/20, at 1:05 p.m. NA-B was observed in R13's room. Signage on R13's room door indicated she was "Positive." NA-B was observed removing isolation gown she was wearing and hung it on a wooden closet door near R13's room entry. The interior portion of the isolation gown was in direct contact with the wooden closet door. NA-B exited R13's room, removed her gloves, and performed hand hygiene.

On 11/9/20, at 1:15 p.m. R1's call light was observed to be on. NA-A remained in the room and was standing near the mechanical lift. R1 remained in his wheelchair and the lift sling was connected to the mechanical lift. At 1:16 p.m. NA-B approached R1's room, put on gloves, and partially entered R1's room. NA-B stood near the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7	F 880		

unoccupied bed immediately inside of R1's entryway, and stated, "Is this my gown?" NA-B then grabbed the patient gown which was laying on the unoccupied bed, and put it on.

On 11/9/20, at 1:21 p.m. NA-B was observed wheeling a gray cart which contained water pitchers down a hallway. NA-B walked near R1's room entry and put on a patient gown which was laying on the unoccupied bed. One gown remained on the unoccupied bed. NA-B put on gloves. NA-B approached R1 and took a urinal from him.

On 11/9/20, at 1:23 p.m. a yellow cloth isolation gown was observed hanging on a hook outside of R15's room. At this time an interview was conducted with NA-A. NA-A stated the yellow cloth isolation gown was hers, and she reused it in rooms in which residents were positive for COVID-19. NA-A confirmed two patient gowns were on the unoccupied bed inside of R1's room. NA-A denied the patient gowns inside of R1's room, were shared. NA-A stated she knew what patient gown belonged to her because her coworkers gown was "darker." NA-A stated she did not believe the patient gowns were in direct contact with one another.

On 11/9/20, at 2:00 p.m. NA-A was observed to put on the yellow cloth isolation gown which was hanging on a hook outside of R15's room. NA-A approached R16's room, put on gloves, entered the room, and walked to the bathroom. Signage on R16's room indicated "Positive." At 2:07 p.m. NA-A wheeled R16 out of the bathroom and assisted her with putting on a sweater. NA-A removed the yellow cloth isolation gown and hung it on the exterior of R16's room door.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 On 11/9/20, at 3:07 p.m. an unidentified staff person was observed to exit R14's room with a yellow cloth isolation gown on. The staff person removed her gloves, performed hand hygiene, and returned to R14's room, and hung the yellow isolation gown on inside R14's room near the entry. On 11/9/20, at 3:17 p.m. an interview was conducted with the DON and RN-A. RN-A stated the facility only had cloth isolation gowns, and the facility would run out of isolation gowns if they were not reused. RN-A stated the facility ran out of disposable isolation gowns. RN-A stated isolation gowns were laundered off-site, and laundry was picked up on Monday, Wednesday, and Friday. RN-A stated the facility's supply of cloth isolation gowns was "troublesome" on Monday and Tuesdays due to the turnaround time from the weekend. RN-A stated yellow isolation gowns were on backorder and the facility was unable to obtain additional gowns due to limited supply ordering. RN-A stated the facility contacted the State Emergency Operations Center (SEOC), emergency preparedness coalition, and COVID-19 case manager regarding isolation gown shortages. The DON stated isolation gowns were able to be reused between COVID-19 positive residents unless the isolation gown was visibly soiled. The DON stated a "clean cart" was kept outside of each COVID-19 negative resident room, and staff were to put on a clean gown prior to entering a COVID-19 negative resident room. The DON confirmed staff should not enter COVID-19 positive resident rooms without an isolation gown on. On 11/10/20, at 9:06 a.m. NA-C was observed	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9	F 880		

exiting a soiled utility room with a bedpan. NA-C had an isolation gown and gloves on. NA-C entered R17's room and placed the bedpan in a nightstand near R17's bed. Signage on R17's room indicated "Positive." NA-C exited the room and hung the isolation gown on a hook near the nurse manager's office.

On 11/10/20, at 9:16 a.m. R2's call light was observed to be on. Signage on R2's door indicated "Positive." A blue disposable isolation gown was noted to be hanging inside the entry of R2's room. At 9:18 a.m. NA-B knocked on R2's door and stated, "What do you need girl?" R2 requested to sit up. NA-B grabbed the blue disposable isolation gown from inside R2's room entry, and put it on. NA-B closed R2's room door. Within the minute, NA-B exited R2's room, and the blue disposable isolation gown was again observed hanging inside R2's room entry. At 9:22 a.m. NA-B again entered R2's room and put on the blue disposable isolation gown which remained inside R2's room entry. NA-B placed a red cup on R2's bedside table, and again hung the blue disposable isolation gown inside R2's room entered, and exited. R2's room was continuously observed at this time.

On 11/10/20, at 10:08 a.m. the DON was observed walking down the hallway with disposable isolation gowns. The DON stated the facility found additional disposable gowns, but "this is the end of it."

On 11/10/20, at 10:17 a.m. RN-B was observed to obtain and put on a blue disposable isolation gown from a cart outside of R1's room. RN-B entered R1's room with an insulin pen and glucometer. RN-B took R1's blood sugar and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10	F 880		

administered insulin. RN-B removed the blue isolation gown and laid it on an unoccupied bed located near R1's room entry.

On 11/10/20, at 10:22 a.m. the DON was observed entering R2's room and put on the blue disposable isolation gown (previously worn by NA-B) near R2's room entry. The DON closed R2's room door. At 10:27 a.m. the DON opened R2's room door, took off the blue disposable isolation gown, and hung it near R2's room entry.

On 11/10/20, at 10:49 a.m. RN-B stated staff were playing "musical gowns." NA-C was observed obtaining a green disposable isolation gown from a cart outside of R1's room, and put it on. NA-C entered R1's room and approached him. NA-C exited R1's room at 10:51 a.m., and then walked near R15's room and leaned her back against the wall directly below the hook where RN-B's isolation gown was previously hung. At 10:53 a.m. NA-C obtained a meal tray and walked it outside of R3's room. NA-C held the outer edge of the meal tray directly against her abdominal area and green disposable isolation gown. NA-C then handed the meal tray to NA-B who was in R3's room. NA-C then hung the green disposable isolation gown outside of R15's room.

On 11/10/20, at 11:20 a.m. RN-B put on a yellow cloth isolation gown which was hanging on a hook outside of the nurse mangers office. RN-B proceeded to prepare and deliver medications to R15, R17, and R18. RN-B then hung the yellow cloth isolation gown in the hallway near the dayroom.

On 11/10/20, at 11:23 a.m. an alarm sounded in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11	F 880		

R5's room. Signage on R5's door indicated "Negative." The ADON put on gloves and a green disposable isolation gown which was hanging on a hook near the room entry. The ADON brought the resident to the bathroom. At 11:30 a.m. the ADON exited the bathroom with R5, and assisted him to a recliner. The ADON removed the green disposable isolation gown and hung it on a hook near the room entry.

On 11/10/20, at 11:43 a.m. NA-B approached R15's room and asked what the he needed. NA-B obtained a green disposable isolation gown from a cart outside of R15's room, and entered his room. Within the minute, NA-B removed the green disposable isolation gown and hung it near R15's entry door.

On 11/10/20, at 12:03 p.m. NA-C approached R1's room. R1 stated he needed to have a use the toilet. NA-C obtained a green disposable isolation gown from a cart outside of R1's room, and put it on. R1 was laying in bed. NA-C entered R1's room and closed the door. At 12:07 p.m. NA-C opened R1's room door, removed the green disposable isolation gown, and hung it on a knob of a lower closet door and exited the room. At 12:15 p.m. NA-C partially entered R1's room. R1 stated he was done. NA-C stated she would be back.

On 11/10/20, at 12:21 p.m. NA-C put on the blue disposable isolation gown (previously worn by RN-B) which was hanging on the exterior of R4's room door. NA-C put on gloves, entered the room, and asked R4 if he wanted any uneaten items off of his meal tray. NA-C exited R4's room at 12:13 p.m. and placed the meal tray on a cart. NA-C removed the blue disposable isolation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12	F 880		

gown and again hung it on the exterior of R4's room door.

On 11/10/20, at 12:35 p.m. NA-B and NA-C approached R1's room. NA-C entered R1's room and put on the green disposable isolation gown which was hanging on the knob of a lower closet door. NA-B obtained a green disposable isolation gown from a cart outside of R1's room. NA-B wheeled a mechanical lift into R1's room. NA-B then closed R1's door. At 12:49 p.m. NA-B wheeled the mechanical lift out of R1's room. NA-B removed the green disposable isolation gown and hung it on the knob of a lower closet door in R1's room. R1 was moved from the bed to a wheelchair. NA-B obtained a pair of socks and handed them to NA-C who was still in R1's room. NA-C approached R1 and put socks on his feet. NA-C removed the green disposable isolation gown and hung it over the green disposable isolation gown which was worn by NA-B. NA-C exited R1's room.

On 11/10/20, at 1:43 p.m. an interview was conducted with NA-B. NA-B stated she hung her used isolation gowns on hooks in rooms she was assigned. NA-B stated she also wrote her name on the back of the gowns. NA-B stated others should not reuse the gowns she had worn. NA-B stated she also assisted NA-C on her hallway. NA-B stated she hung the isolation gowns she wore on resident closet doors, and NA-C hung her isolation gowns on hooks.

On 11/10/20, at 1:45 p.m. an interview was conducted with NA-C. NA-C stated staff were instructed isolation gowns were able to be reused between COVID-19 positive residents. NA-C stated isolation gowns only needed to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13	F 880		

changed when entering a resident room who was negative for COVID-19. NA-C stated NA-B labeled her gowns with a marker, so she knew what gowns belonged to her. NA-C denied isolation gowns were hung in COVID-19 positive resident rooms. NA-C stated she started her shift with all new gowns. NA-C confirmed the green disposable isolation gown hanging inside of R3's (COVID-19 negative) room belonged to her.

On 11/10/20, at 1:50 p.m. an interview was conducted with RN-B. RN-B stated isolation gowns could be reused, unless soiled, for COVID-19 positive residents. RN-B stated separate gowns needed to be used for COVID-19 negative residents. RN-B stated she had her own gown and it was hanging in the hallway, and stated others would be afraid to use her gown. RN-B stated she would hang her isolation gown in the same place after use. RN-B stated she used the same gown for the shift, and then put it in the laundry.

On 11/10/20, at 2:09 p.m. the two green disposable isolation gowns remained hanging on the knob of the lower closet door in R1's room. Neither green disposable isolation gown was labeled. An interview was conducted with NA-B. NA-B confirmed the two isolation gowns were in direct contact with each other. NA-C stated they would be "pitching them anyways." NA-B disposed of the isolation gowns.

On 11/10/20, at 2:11 p.m. an interview was conducted with NA-B. NA-B stated she had been using the green disposable isolation gown which was hanging near the entry in R5's room. NA-B stated she knew the isolation gown belonged to her because she marked it with a Sharpie on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14	F 880		

neckline.

On 11/10/20, at 2:12 p.m. a yellow cloth isolation gown was observed hanging on a door near a nurses' station. An interview was conducted with licensed practical nurse (LPN)-A. LPN-A stated she reused the same isolation gown throughout her shift unless it was dirty. LPN-A stated the yellow cloth isolation gown hanging on the door belonged to her, and she removed the isolation gown in the hallway and hung it up after use. When asked how staff distinguish which isolation gown they used, LPN-A stated she knew which gown belonged to her.

On 11/10/20, at 2:22 p.m. an interview was conducted with NA-E. NA-E stated she was instructed isolation gowns were able to be reused unless soiled with stool or urine. NA-E stated isolation gowns were unable to be reused between COVID-19 positive and negative residents. NA-E stated she hung her isolation gown on a hook between use, and told others it belonged to her. NA-E stated she would obtain a new isolation gown every two to three hours. NA-E stated she would not recommend staff share an isolation gown, however, the facility did not instruct staff they could not.

On 11/10/20, at 2:28 p.m. an interview was conducted with the ADON. The ADON stated the green disposable isolation gown in R5's room was only for her use.

On 11/10/20, at 3:47 p.m. an interview was conducted with the DON and RN-A. The DON stated staff could reuse isolation gowns between COVID-19 positive residents as long as the isolation gowns were not visibly soiled. The DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15	F 880		

stated isolation gowns were switched out at the end of a shift. The DON stated there was to be one gown per staff person. The DON confirmed there was not a system in place for staff to determine which isolation gown they had worn, and stated each staff-person was responsible to remember where they put their isolation gown. The DON stated it was not acceptable for staff to hang isolation gowns on top of each other. RN-A stated the facility did not want staff to share a gown for "infection control." RN-A stated the facility put hooks up in rooms and some did not stay.

Centers for Disease Control and Prevention (CDC) Strategies for Optimizing the Supply of Isolation Gowns dated 10/9/20, directed "The risks to HCP [health care professionals] and patient safety must be carefully considered before implementing a gown reuse strategy. Disposable gowns generally should NOT be re-used, and reusable gowns should NOT be reused before laundering, because reuse poses risks for possible transmission among HCP and patients that likely outweigh any potential benefits. Similar to extended gown use, gown reuse has the potential to facilitate transmission of organisms (e.g., C. auris) among patients. However, unlike extended use, repeatedly donning and doffing a contaminated gown may increase risk for HCP self-contamination. If reuse is considered, gowns should be dedicated to care of individual patients. Any gown that becomes visibly soiled during patient care should be disposed of or, if reusable, laundered."

COVID-19 POSITIVE STAFF

Review of NA-C's laboratory report dated 11/6/20,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16	F 880		

indicated NA-C was positive for COVID-19.

Review of NA-C's timecard dated 10/1/10, through 11/11/20, indicated NA-C had worked at the facility on 11/6/20, 11/7/20, 11/8/20, 11/10/20, and 11/11/20.

An untitled facility provided document, received 11/12/20, indicated NA-D had a positive rapid COVID-19 test on 10/28/20.

Review of NA-D's timecard dated 10/1/20, through 11/11/20, indicated NA-D had worked at the facility on 10/28/20, 10/29/20, 10/31/20, and 11/1/20.

Review of NA-E's laboratory report dated 11/6/20, indicated NA-E was positive for COVID-19.

Review of NA-E's timecard dated 10/2/20, through 11/11/20, indicated NA-E had worked at the facility on 11/6/20, 11/9/20, 11/10/20, and 11/11/20.

Review of LPN-A's laboratory report dated 10/29/20, indicated LPN-A tested positive for COVID-19. A handwritten note on the laboratory report, further indicated LPN-A had a positive rapid COVID-19 test on 10/27/20.

Review of LPN-A's timecard dated 10/1/20, through 11/10/20, indicated LPN-A had worked at the facility on 10/27/20, 11/4/20, 11/5/20, and 11/6/20.

On 11/10/20, at approximately 1:00 p.m. review of the facility provided Excel sheet showed a list of employees who worked between 10/27/20,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17 through 11/8/20.	F 880		

On 11/16/20, at approximately 12:00 p.m. a review of the facility Employee Illness Log for October and November 2020 was completed. The employee illness log indicated registered nurse (RN)-D had symptoms of fever, diarrhea, irregular heart rate, chest pain on dates of 10/29/20, and 10/30/20. According to the excel sheet of employees working between 10/27/20, through 11/8/20, RN-D worked on 10/29/20, and 10/30/20.

The employee illness log indicated nursing assistant (NA)-D had symptoms of fever on 11/2/20, and worked on 11/10/20, according to the excel sheet provided by the facility. Column indicated NA-D had a positive COVID-19 test on 11/10/20.

The employee illness log indicated NA-J had symptoms of cough, aching earache on 10/30/20, and worked on 10/30/20, according to the excel sheet provided by the facility.

On 11/12/20, at 2:19 p.m. the ADON was interviewed. The ADON stated employee ill calls are taken by staff on a "green" form. The form was filled out, and sent to administration and to the infection control nurse. The ADON stated she stopped tracking employee illness in real time on 10/19/20. The ADON stated employee surveillance should be done in real time.

On 11/10/20, at 1:45 p.m. an interview was conducted with NA-C who was working in the facility at the time of the interview. NA-C stated she tested positive for COVID-19 on 11/6/20. NA-C stated she initially lost her sense of taste

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18	F 880		

and smell, however, it had returned. NA-C stated she was fatigued, but worked in long term care. NA-C confirmed she was working with all residents and was not restricted from work after testing positive.

On 11/10/20, at 2:12 p.m. an interview was conducted with LPN-A. LPN-A stated she had tested positive for COVID-19, however, was past the "14 days." LPN-A stated she was asymptomatic. LPN-A confirmed she worked in the facility after testing positive for COVID-19, and prior to the expiration of her quarantine. LPN-A stated she was only allowed to work with residents who tested positive for COVID-19

On 11/10/20, at 2:22 p.m. an interview was conducted with NA-E who was working in the facility at the time of the interview. NA-E stated she had tested positive for COVID-19 on 11/6/20. NA-E denied symptoms, and stated she was "shocked" when she learned she was positive. NA-E denied caring for COVID-19 negative residents.

On 11/10/20, at 3:47 p.m. an interview was conducted with the DON and RN-A. The DON confirmed COVID-19 positive staff were working at the facility, and stated the facility attempted to keep COVID-19 positive staff from working on hallways where COVID-19 negative residents resided. RN-A confirmed the facility learned NA-C was positive for COVID-19 on 11/6/20. RN-A confirmed NA-C was scheduled on a nursing unit where residents were negative for COVID-19. RN-A stated NA-C was not supposed to enter resident rooms who were negative for COVID-19. RN-A stated she would expect the other nursing assistants to help her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19 On 11/10/20, at 5:24 p.m. an interview was conducted with the ADON. The ADON stated she did not know if the facility received approval from the state or the COVID-19 case manager to utilize COVID-19 positive staff for resident care. The ADON stated asymptomatic positive staff were able to do direct care with residents who were positive for COVID-19. The ADON stated the facility used MDH contingency guidance. The Minnesota Department of Health (MDH) Clarification of Staffing Options for Congregate Care Facilities Experiencing Staff Shortages (https://www.health.state.mn.us/diseases/coronavirus/hcp/staffoptions.html) undated, directed, "If the facility is designated to be in an acute staffing crisis by the SEOC, the MDH Commissioner may grant the facility the ability to allow asymptomatic HCW positive for COVID-19 to return to work in roles that include direct care for residents with confirmed COVID-19. Positive HCW cannot provide direct care or interact with residents or staff who have not been diagnosed with COVID-19. The criteria above must be met and approval from the MDH Commissioner must be given before allowing asymptomatic staff with confirmed COVID-19 to work. Ill or symptomatic COVID-19-positive staff should never enter the facility." Infection Prevention and Control Manual Interim Policy for Suspected or Confirmed Coronavirus (COVID-19) from the Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) dated 2020, was provided by the facility as the policy they were following. The guidance indicated employees would be actively screened for signs and symptoms of COVID-19	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20 when they report to work-beginning of their shift. If employee is ill, employee will be provided with a clean facemask and will immediately leave the facility. Symptoms listed were as follows: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose. The IJ was removed at 3:48 p.m. on 11/13/20, when it was verified the facility reviewed applicable policies, staff education occurred, and staff were interviewed and observed implementing proper utilization of PPE.	F 880		
F 886 SS=K	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of	F 886		1/15/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 21	F 886		

asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county;
(v) The response time for test results; and
(vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.

§483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests;

§483.80 (h)((3) For each instance of testing:
(i) Document that testing was completed and the results of each staff test; and
(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test.

§483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19.

§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested.

§483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to test all active staff for COVID-19 after a COVID-19 outbreak occurred. In addition, the facility failed to perform routine COVID-19 testing based on county positivity rates. This practice resulted in an immediate jeopardy (IJ) situation which had the potential to affect 5 of 26 residents (R1, R3, R5, R9, and R11) who resided at the facility and were not infected with COVID-19, and did not have a previous COVID-19 diagnosis. The IJ began on 11/2/20, when it was determined the facility failed to test all active staff after a resident tested positive for COVID-19 on 10/26/20. The director of nursing (DON), assistant director of nursing (ADON), and registered nurse (RN)-A were notified of the IJ at 4:35 p.m. on 11/13/20. The IJ was removed on 11/16/20, but noncompliance remained at the lower scope and severity level of E, pattern which indicated no actual harm with potential for more than minimal harm that is not IJ. Findings include: R1's laboratory reports dated 11/2/20, 11/5/20, and 11/10/20, indicated R1 was negative for COVID-19. R3's laboratory reports dated 11/2/20, 11/5/20, 11/10/20, and 11/13/20, indicated R3 was negative for COVID-19. R5's laboratory report dated 11/5/20, indicated R5 was negative for COVID-19. An undated document provided by the facility indicated R5's	F 886	The residents that may be affected by this deficiency include the current 6 residents who currently have not had a known infection of COVID 19. Policy for COVID 19 testing of staff and residents was created. Testing cycle is dependent upon last known positive COVID 19 case within the facility as well as the current county positivity rate. Staff and residents that do not have a history of COVID 19 in the last 90 days have been educated on current testing cycle. Staff that are not compliant with testing cycle will removed from the schedule and not allowed to work until testing meets current outbreak guidelines per Pine County positivity rates. All COVID 19 positive staff who have not met the established return to work criteria were removed from the schedule on 11/12/20. Lakeside Health and Rehab reviewed and continues to use the COVID-19 Recommendations for Health Care Workers guidance from MDH for staff return to work and remains current. Training Plan Staff have been educated on current testing requirements on 11/16/20, 11/27/20, 12/11/20 and upon an individual	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 23 subsequent COVID-19 test was "spilled" and unable to be performed on 11/9/20. R9's laboratory reports dated 11/2/20, 11/5/20, and 11/10/20, indicated R9 was negative for COVID-19. R11's laboratory reports dated 11/5/20, and 11/10/20, indicated R11 was negative for COVID-19. R12's progress notes dated 10/25/20, at 12:52 p.m. indicated R12 had a temperature of 102.9 degrees Fahrenheit, was "achy," and had a headache. R12 was put on isolation precautions. R12's progress notes dated 10/26/20, at 5:16 p.m. indicated R12 was presumptively positive for COVID-19 after an antigen (rapid) COVID-19 test was performed. Review of R12's St. Jude Laboratories report dated 10/27/20, indicated R12 was positive for COVID-19. Pine County COVID-19 Positivity Rates 10/19/20 - 10/25/20 = 3.4% 10/26/20 - 11/1/20 = 7% Employee timecards dated 10/1/20, through 11/13/20, and were reviewed and indicated the following employees worked at the facility after a COVID-19 outbreak occurred on 10/26/20: Administrative: Chief financial officer, a payroll staff-person, the administrative assistant, and receptionist.	F 886	basis as needed. Quality Assurance All staff and residents who have not had a positive COVID19 test in the last 90 will be audited weekly for compliance x2 weeks, then 5 staff weekly x2, then 5 staff monthly for 3 months, and then 1 staff quarterly or until 100% compliance is achieved. DON, IP or designee are responsible for compliance and these audits will be reviewed at the QAPI meetings. Compliance will be achieved by 1/15/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 24	F 886		

Nursing:
Nursing assistant (NA)-G, NA-I, NA-H, and RN-C.

Dietary:
Dietary aide (DA)-A, DA-B, DA-C, DA-D, and the dietary manager.

Activities:
Activities aide (AA)-A, and AA-B.

Therapy:
Occupational therapist (OT)-A, certified occupational therapist assistant (COTA)-A, physical therapy assistant (PTA)-A,

The facility lacked documentation the above employees had a COVID-19 test performed prior to 11/12/20.

A facility document titled Active Lakeside employees who are not known to have been tested following outbreak testing dated 11/12/20, indicated the following:
- NA-G, NA-I, COTA-A, PTA-A, the dietary manager, the payroll staff-person, administrative assistant, chief financial officer, and receptionist refused COVID-19 testing.
- AA-A, AA-B, DA-A, DA-B, DA-C, DA-D, RN-C, OT-A were not present for COVID-19 testing.
- The document lacked indication why NA-H was not tested for COVID-19.

A document titled Initial Rapid Testing undated, indicated 37 of 63 employees were not tested for COVID-19.

On 11/12/20, at 10:45 a.m. an interview was conducted with the DON. The DON stated the facility encouraged staff to be tested for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 25	F 886		

COVID-19, however, staff were not required to be tested. The DON stated some staff who declined testing, and as long as they were asymptomatic, testing was not required.

On 11/12/20, at 11:08 a.m. an interview was conducted with the ADON. The ADON stated the facility encouraged staff to be tested for COVID-19, but the facility could not mandate testing. The ADON stated many employees did not have insurance, and the facility would have had to pay for the tests, and they could not do it right now. The ADON stated the facility was allowing asymptomatic staff to work even if they were not tested for COVID-19. The ADON stated some staff would not come in on their day off and be tested for COVID-19.

On 11/12/20, at 2:19 p.m. an interview was conducted with the ADON. The ADON stated the facility COVID-19 outbreak began on 10/25/20. The ADON stated R12 was the first resident to develop a temperature. The ADON stated the facility started testing for COVID-19 on 10/26/20, and additional testing was conducted 10/27/20, through 11/30/20, for residents and staff who were willing. The ADON stated initial COVID-19 testing was conducted by using rapid kits, however, the facility ran out of test kits. The ADON stated the facility began using "PCR COVID-19" tests on 11/3/20. The ADON stated three residents, who were not tested for COVID-19 due to running out of tests, were tested on 11/3/20, and "willing staff" were tested beginning on 11/4/20. The ADON stated 28 staff were not tested for COVID-19. The ADON stated 25 of 28 employees still needed to be tested for COVID-19, and the others had refused. The ADON stated Pine County COVID-19 positivity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 26	F 886		

rates were "pretty high." The ADON stated had the facility tested all staff it would had been more helpful.

On 11/12/20, at 3:35 p.m. an interview was conducted with RN-A. RN-A stated the number of staff who refused COVID-19 testing seemed high, but if the ADON provided the number it was probably right. RN-A stated staff who refused COVID-19 testing may or may not be working at the facility.

On 11/12/20, at 4:30 p.m. an interview with the ADON was conducted. The ADON stated she believed 37 facility employees (contrary to the initial number stated) were not tested for COVID-19. The ADON stated many of the employees who were not tested, were casual or had not worked.

On 11/13/20, at 9:57 a.m. an interview was conducted with PTA-A. PTA-A stated she was tested for COVID-19 today.

On 11/13/20, at 10:17 a.m. an interview was conducted with NA-I. NA-I stated she was tested for COVID-19 today, however, confirmed she was not previously tested and worked at the facility. NA-I stated she was not tested by choice.

On 11/13/20, at 10:37 a.m. an interview was conducted with COTA-A. COTA-A stated she was tested for COVID-19 today. COTA-A confirmed was not previously tested for COVID-19 and had worked in the facility.

On 11/13/20, at 12:09 p.m. an interview was conducted with the ADON. The ADON stated the facility began biweekly COVID-19 testing on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 27	F 886		

11/9/20. At 12:09 p.m. the ADON stated NA-I was tested today, however, NA-I previously would not come in for testing and refused. The ADON stated COTA-A was tested for COVID-19 today, but had previously refused due to her personal beliefs. The ADON stated a couple of staff who were not tested for COVID-19, were scheduled to work during the upcoming weekend.

On 11/13/20, at 1:46 p.m. an interview was conducted with the DON. The DON confirmed the facility did not conduct routine COVID-19 testing based on county positivity rates, prior to 10/26/20. The DON stated staff who were asymptomatic and refused testing were allowed to work after the facility COVID-19 outbreak. The DON stated symptomatic staff were not allowed to work. The DON stated the facility fell through the cracks regarding request for testing supplies.

The facility lacked COVID-19 testing logs.

A document titled Lakeside COVID-19 Testing undated and received on 11/13/20, directed, "Testing must be completed twice a week as instructed or you cannot work in the building."

CMS QSO-20-38-NH dated 8/26/20, directed, "Routine testing should be based on the extent of the virus in the community, therefore facilities should use their county positivity rate in the prior week as the trigger for staff testing frequency ..." QSO-20-38-NH further directed, "Facilities must have procedures in place to address staff who refuse testing. Procedures should ensure that staff who have signs or symptoms of COVID-19 and refuse testing are prohibited from entering the building until the return to work criteria are met. If outbreak testing has been triggered and a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	11/16/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 886	Continued From page 28 staff member refuses testing, the staff member should be restricted from the building until the procedures for outbreak testing have been completed. The facility should follow its occupational health and local jurisdiction policies with respect to any asymptomatic staff who refuse routine testing." The IJ was removed at 3:18 p.m. on 11/16/20, when it was verified the facility developed a COVID-19 testing policy, staff were educated and interviewed.	F 886		