Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 30, 2024

Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

RE: CCN: 245280
Cycle Start Date: December 6, 2023

Dear Administrator:

On January 23, 2024, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 28, 2023

Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

RE: CCN: 245280
Cycle Start Date: December 6, 2023

Dear Administrator:

On December 6, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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, 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 6, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by June 6, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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 electronic 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.

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 12/4/23-12/6/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a 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 On 12/4/23-12/6/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H52807063C (MN00089988) H52807064C (MN00089941) H52807065C (MN00088707) H52807066C (MN00089656) H52807067C (MN00089443) H52807068C (MN00089450) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

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

Electronically Signed | 01/03/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		1/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience for 1 of 1 residents (R17) who required assistance with dining. Findings include: R17's Admission Record printed 12/6/23, indicated R17's diagnoses included traumatic brain injury, Parkinson (nervous system disorder progressive movement disorder that causes tremor in one hand, stillness or slowing of movement), and dementia. R17's quarterly Minimum Data Set (MDS) assessment, dated 10/4/23, identified R17 rarely to never is understood, occasionally understands, does not speak, and is totally dependent with all care including assistance with feeding from assistance of 1 person. R17's care plan printed 12/6/23, identified an activities of daily living (ADL) self care performance deficit and requires assistance by 1 staff to eat. During an observation on 12/4/23 at 12:39 p.m., R17 was sitting in his Broda chair (positioning wheelchair) at a table in the dining room with his	F 550	Staff member “NA-A” educated on 12/6/2023 on proper handling of resident food. All nursing staff education on when to wear gloves while feeding a resident was completed on 12/7/2023 all staff educated as to inform staff on any resident that needs feeding. For R-17 Staff member NA-A and all other nursing staff were educated on proper feeding of a dependent feeding of a resident. All nursing staff communication on 12/6/2023 allowed all nursing staff to understand the situation and education so no other residents that are dependent on feeding will be affected. On 12/6 resident R-17’s kitchen pod was educated on appropriately serving resident food so it can be warm and palatable. Dietary Manager policy reviewed by dietary manager on 12/7/2023 and updated to include meal delivery to residents who need to be fed. The policy states “The dietary department will serve residents their meal when it is serving time, and the resident is present. The only exception is residents who are dependent with feeding, will not be served any items until nursing staff is set with that resident.” All dietary and nursing staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 meal in front of him. At 1:09 p.m., nursing assistant (NA)-C sat down to assist R17 with the meal without reheating. At 1:10 p.m., NA-C went to deliver a tray to another residents room and returned to assist R17 at 1:12 p.m. At 1:15 p.m., NA-C went to deliver another room tray. At 1:19 p.m. returned and assisted R17 until he was done with this meal. During observation on 12/6/23 at 7:17 a.m., R17 was brought to the dining room and placed at a bedside table in the dining room. At 7:31 a.m., R17 had peanut butter toast on his table. At 7:35 a.m., R17 received his medications from licensed practical nurse (LPN)-A. Toast continued to sit untouched on the plate. At 7:58 a.m., toast remained on his plate on his table. R17 has made no attempt to feed self. At 8:18 a.m., R17 continued with toast on his plate on table with no attempt to feed self. At 8:29 a.m., dietary manager asked NA-A if there was someone to assist R17 with his breakfast. NA-A then stood beside R17 and picked up toast that was served at 7:31 a.m. with ungloved hands and gave R17 a bite and set toast back on plate. At 8:31 a.m., NA-A picked up toast and gave R17 another bite with ungloved hands. At 8:33 a.m., NA-C went to a closet by the nurses station and returned with gloves on her hands and continued to assist R17 with this toast. At 8:41 a.m., R17 finished eating his toast. NA-C requested oatmeal. NA-C assisted R17 with eating his oatmeal and R17 had multiple coughing spells. NA-C informed LPN-A who responded that NA-C should stop feeding R17. During interview on 12/6/23 at 9:09 a.m., NA-A confirmed she did not reheat or ask for new toast for R17. NA-A confirmed R17 had to wait for	F 550	educated on policy change on 12/7/2023 so to not allow food to be served too early to any resident who is dependent on feeding. All staff education on 1/4/2023. Audits will be completed by the dietary manager regarding food time and proper feeding techniques of staff for resident feedings. These audits will be done weekly at random and brought to the QAPI committee for review and acceptance prior to ending of the audits.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 4 assistance this morning as the NA's were busy getting everyone up before assisting him. During interview on 12/6/23 at 4:08 p.m., the director of nursing (DON) confirmed staff should not pick up food with their hands unless wearing gloves. The DON stated food should not be placed in front of R17 until staff are available to assist R17 with the meal and staff should remain with the resident until R17 is finished with his meal. The facility Feeding the Resident (dependent eating) procedure undated included: -observe universal precautions or other infection control standards as approved by appropriate facility committee. -take tray to resident and set directly in front of resident -never make the resident feel that the meal must be hurried and but that the procedure is pleasant. Give him/her your complete attention. Sit so you are at the same level as the resident when possible.	F 550		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		1/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 5 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 580	Staff member LPN-D educated on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 6 facility failed to notify a provider of a significant physical change for 1 of 1 resident (R10) reviewed for notification of change. Findings include: R10's face sheet printed on 12/6/23, included a diagnosis of congestive heart failure, and new diagnoses of hemiplegia (paralysis of one side of the body) and hemiparesis (partial paralysis on one side of the body) following a stroke, affecting right dominate side with aphasia (loss of ability to understand or express speech) dated 12/1/23. R10's annual Minimum Data Set (MDS) assessment dated 10/11/23, indicated R10 was cognitively intact, had clear speech, was understood, and could understand. R10 had been independent with most all activities of daily living (ADL's). R10's care plan dated 12/4/23, indicated R10 had a stroke affecting her right dominate side and expressive aphasia, and would show improvement to maximum potential with mobility and cognition. R10's physician orders dated 11/4/21, included a standing order for urine specimen for UA (urinalysis) with reflex to culture if protocol criteria were met for signs and symptoms of UTI (urinary tract infection). During an interview on 12/4/23 at 1:53 p.m., family member (FM)-F stated R10 had recently had a stroke on 11/27/23, and had difficulty speaking in the days prior to that stroke and had not been acting her usual self. FM-F thought R10 had another UTI causing the behavior changes	F 580	12/7/2023 by Director of Nursing on proper notification of provider with any negative change in condition for R10. The Director of Nursing will audit LPN-D's charting weekly x 1 month then once every two weeks to monitor compliance with LPN-D's charting and notification. Policy reviewed by DON and IDT nursing team. Education was provided to all nursing staff on 12/7/2023 to prevent any other resident's provider being delayed of notification. On 12/7/2023 LPN-D and all nursing staff educated on proper documentation of assessments in the electronic medical chart. DON and Nursing administration to perform weekly audits on provider notifications and assessments indicating the change in condition for all residents. Any change in condition the DON and Nursing Administration team will look at assessments, timing of notifications to family and providers, outcomes and results. These audits will be brought to the QAPI committee for review and acceptance prior to the ending of the audits. All staff education on 1/4/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 7 and took R10 to the emergency room (ER) herself to have R10 checked on 11/24/23. During an interview on 12/5/23 at 1:26 p.m., licensed practical nurse (LPN)-D stated she had been working when R10 had experienced the "first stroke symptoms" on 11/23/23. LPN-D stated on 11/23/23, R10 became very confused, couldn't speak, and shook her head yes or no in answer to questions. LPN-D admitted she had not notified a provider despite observing R10's inability to speak. LPN-D looked in the electronic medical record (EMR) to see if she had documented R10's inability to speak and stated she had not, and should probably enter a late note. LPN-D stated she didn't document R10's changes because she was going out the door at shift change and had just stayed long enough to help do the neuro (neurological) assessment. LPN-D stated R10's neuro assessment had been okay, and she informed on-coming nurse, (LPN)-I of the results. LPN-D stated she assumed LPN-I would document the changes in R10's condition and notify the provider if symptoms continued. Progress note dated 11/23/23 at 5:47 p.m., written by LPN-I indicated: family member (FM)-F stated R10 was out of it, doesn't readily answer questions unless yes or no and was sleepy. FM-F had been adamant R10 had a urinary tract infection (UTI) though R10 denied pain or burning on urination. Vital signs were stable. Progress note dated 11/23/23, at 6:47 p.m., written by LPN-I indicated: nurse practitioner (NP)-F was called and stated FM-F had texted her regarding R10 and concern she has a UTI. Confirmed R10 did not fit criteria for a UA/UC (urinalysis and urine culture) but [a UA] could be	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 8 done at the family's insistence. Progress note dated 11/23/23, at 9:00 p.m., written by LPN-I indicated FM-F stated she didn't know why she had to wait for a [urine] culture report -- she knew R10 had a UTI and said she just might take R10 to the ER herself. Twenty minutes later, R10 was observed being taken down the hallway by FM-F to the ER. LPN-I up-dated the on-call RN (registered nurse). Progress note dated 11/23/23, at 10:45 p.m., written by (LPN)-G indicated R10 had returned from the ER with an order for an antibiotic [for diagnoses of UTI]. During an interview on 12/5/23 at 3:35 p.m., registered nurse (RN)-A who was also the nurse manager stated no one had informed her about R10's inability to speak on 11/23/23, adding staff should have called the on-call nurse, registered nurse (RN)-F. During an interview on 12/5/23 at 3:47 p.m., RN-F stated she had received a call regarding R10 on 11/23/23, and the family wanting a urinalysis believing R10 had been experiencing symptoms due to a UTI. RN-F stated she instructed staff to call the on-call provider. RN-F stated staff did not report anything about R10 not being able to speak; but did say something about confusion. During an interview on 12/5/23 at 3:51 p.m., nurse practitioner (NP)-D stated on 11/23/23 at 5:46 p.m., FM-F had texted her, noting R10 had been "disoriented today, urine smalls strong, using fingers to eat." NP-D stated she had not been the on-call provider, but FM-F had her phone number and texted her. NP-D stated she	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 9 was unaware R10 had been unable to speak; FM-F did not indicate that in her text message - she was focused on a possible UTI. NP-D stated R10 could have been having a TIA on 11/23/23, with the inability to speak and behavior changes. NP-D stated she had reviewed the ER visit note from 11/23/23, and the ER provider had not noticed stroke symptoms. NP-D stated if R10 had been sent to the ER earlier on 11/23/23, it might not have changed the outcome, however it was always good practice to notify a provider anytime a resident experienced a change in condition. ER visit note dated 11/24/23 at 9:24 p.m., indicated the reason for R10's visit was urinary problems. Per FM-F's report, incontinent x3 today, confusion yesterday, today fatigue and weakness and R10 not acting like herself. The ER visit note indicated R10 presented to the ER with confusion yesterday and intermittent abdominal pain. R10 had clear speech, poor recall and moving all extremities. A urinalysis was notable for infection which could explain R10's urinary symptoms, abdominal discomfort, and confusion. The ER provider note indicated they would hold off on radiological studies at that time. Final diagnosis, UTI. According to progress notes and ER visit note, the facility had failed to inform the ER provider of R10's inability to speak on 11/23/23. During an interview on 12/6/23 at 8:33 a.m., the DON was informed of interviews with staff and the failure of a nurse to notify the on-call provider on 11/23/23, when R10 was not able to speak, nor did a nurse document R10's inability to speak. The DON was aware from the ER visit note that the ER provider had not thought R10 was having a stroke as he didn't order imagining tests. The	F 580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 10 DON acknowledged that communication from the facility to the ER on 11/23/23, in the form of an SBAR (situation, background, assessment, recommendation) focused on UTI symptoms, and nothing about R10's inability to speak earlier that day. The DON stated he would have expected nurses to inform a provider when there was a change in a residents condition and to document the findings. The DON stated, yes - there had been an opportunity to notify the provider. The facility Physician Notification policy dated 9/13/23, indicated in the event of a significant change in a resident's physical, mental or psychosocial status in either life-threatening conditions or clinical complications, the facility RN or LPN would inform the resident, consult with the resident's physician or on-call physician. When a resident complained of an acute onset of new, severe pain, difficulty breathing, visual disturbances, increased weakness, difficulty swallowing, dizzy, has behavioral changes or any abnormal feeling, more information must be obtained. After all information was gathered, the physician needed to be contacted. Conditions in which to notify a physician immediately included sudden change in mental status including confusion.	F 580		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 677	R-17's facial hair was addressed by NA	1/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 11 review, the facility failed to provide routine removal of facial hair for 1 of 1 resident (R17) and bathing for 1 of 1 (R30) resident reviewed for activities of daily living (ADLs) who were dependent on staff for cares. Findings include: R17's Admission Record printed 12/6/23, indicated R17's diagnoses included traumatic brain injury, Parkinson (nervous system disorder progressive movement disorder that causes tremor in one hand, stillness or slowing of movement), and dementia. R17's quarterly Minimum Data Set (MDS) assessment dated 10/4/23, indicated R17 does not speak, is rarely understood and occasionally understands. R17 was totally dependent with all activities of daily living cares (ADL's) and had no behaviors including care refusal. R17's care plan printed on 12/6/23, indicated R17 had an ADL self-care performance deficit R/T [related to] dementia, Parkinson's, limited mobility and traumatic brain injury. R17 requires total assist with all ADL's and does not use call light so staff are to anticipate his needs. Shaving was not included separately on the plan of care. During observation on 12/4/23 at 1:21 p.m., R17 was observed sitting in his room in Broda chair (positioning wheelchair) with facial hair stubble present on his lower jaw. R17 was asked if he prefers to be shaved daily and did not respond. During observation on 12/5/23 at 9:32 a.m., R17 was in his Broda (positioning) chair in his room with whiskers 1/8 inch present on lower portion of	F 677	on 12/6/2023, . All nursing staff were educated on 12/7/2023 regarding the trimming of facial hair, unless specifically asked to keep for not only resident R-17 but all residents. Resident R-17 is non-verbal. Therefore, his care plan has been updated that he likes to be clean shaven, his Kardex for the CNA's was also updated. Going forward any nonverbal male or female residents will be care-planned with a Kardex update on their preference of being shaven. For all residents who can give staff feedback on their preference, we will update the care plan and Kardex with those preferences as needed and will be reviewed quarterly at care conferences. Weekly audits of R-17 will be complete by DON or Administrative nursing to ensure compliance of resident being shaven. These audits will be brought to QAPI for review and acceptance prior to ending audits. Regarding R 30's bath resident was offered a bath and bath was given. Education to nursing staff on 12/7/2023. To prevent this from happening again to R 30 or any resident the Point Click Care electronic medical records has been updated to allow an option for a bath refusal to be documented, it did not have a refusal spot prior. This addition to the electronic medical records will allow audits of who is refusing a bath or if a bath has been missed. Resident care coordinators will audit random resident baths weekly to assure compliance. If baths are continuely being rerfused or missed, resident care coordinator will interview	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 12 his face. R17 was asked if he would like to be shaved and did not receive a reply of yes or no back. During observation on 12/6/23 at 8:18 a.m., R17 was in the dining room in his Broda chair. R17 remained unshaven with white whiskers present on his lower face approximately 1/3 inches in length. During interview on 12/6/23 at 9:09 a.m., nursing assistant (NA)-B confirmed there was multiple days of hair growth on R17 and she would ensure he got shaved today. During interview on 12/6/23 at 9:09 a.m., NA-A indicated R17 should be shaved daily and she will ensure it gets done today. During interview on 12/6/23 at 11:36 a.m., registered nurse (RN)-A, also identified as care coordinator, indicated if someone can not communicate their needs, they should be shaved daily. During interview on 12/6/23 at 4:37 p.m., the director of nursing (DON) indicated not all males need to be shaved daily but did confirm R17 can not express his desires. The facility Resident with Electric Razor policy dated 4/30/14, indicated residents should be provided a clean shaven appearance and residents should be shaved daily or as resident prefers. R30's facesheet printed on 12/5/23, included a diagnosis of Covid-19.	F 677	resident and adjust care plan according to resident's preferences. Resident care coordinator will address bath schedule and preferences at care conferences. These audits will be brought to the QAPI committee meeting for review and acceptance prior to the ending of the audits. To monitor all resident's bath and shaving wishes Resident Care coordinator will monitor the bath and shaving audits, they will also discuss preferences with all residents at care conference and PRN. All staff education on 1/4/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 13 R30's quarterly MDS assessment dated 11/15/23, indicated R30 had moderately impaired cognition. R30 had clear speech, was understood, and could understand, had no rejection of cares, and required substantial/maximal assistance by staff for bathing. R30's care plan printed on 12/5/23, indicated R30 preferred showers twice weekly in the evening, and required assistance with activities of daily living (ADL's). During an interview and observation on 12/4/23 at 3:03 p.m., R30, who was in transmission-based precautions after testing positive for Covid-19, stated she had not had a bath for two weeks. A shower was observed in the bathroom in her room. During an interview on 12/5/23 at 10:43 a.m., NA-F displayed a paper form on a clipboard located in the nurses station which indicated the day of the week each resident was scheduled to bathe. The form indicated R30 was to bathe on Wednesday and Sunday evenings. NA-F also pointed out a white board in the nurses station which indicated which residents were to bathe that day. According to the bath form, R30 was to bathe Wednesday 12/6/23, yet her name was on the whiteboard on Tuesday 12/5/23. NA-F stated if a resident refused a bath, their name would stay on white board until they had a bath. NA-F stated she assumed that was why R30's name was on the white board. During an interview on 12/5/23 at 10:55 a.m., RN-F stated bathing was documented by NA's in POC (point of care), under the "TASK" tab for bathing. Together, looked at this documentation.	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 14 From 11/12/23, to 12/3/23, it indicated only one entry for bathing on 11/14/23. On 11/12/23, 11/22/23, 11/26/23, 11/29/23, and 12/3/23, there was a check mark under "ADL activity itself did not occur..." RN-F stated POC did not give NA's an option to document a refusal. RN-F stated that if a resident refused bathing, the NA should tell a nurse and staff should re-approach later. If the resident declined those attempts, the nurse should document it in a progress note. RN-F was informed there had been no documentation of R30 refusing bathing in progress notes. During an interview on 12/5/23 at 11:07 a.m., (NA)-F stated if a resident refused a bath, a NA would re-approach later. If still refused, would tell a nurse. NA-F stated there had been no tub baths during the Covid-19 outbreak since the tub was located in an adjacent unit, however, NA-F stated there were showers in resident bathrooms, including R30's. During an interview on 12/5/23 at 2:14 p.m., (RN)-A who was also a nurse manager, stated after reviewing documentation in the EMR, it indicated R30 did not have a bath or shower since 11/14/23, and there had been no documentation of refusals. RN-A stated she would expect staff to document refusals and to let the nurse know. RN-A did not know if a nurse had been notified and stated usually if a nurse was informed of this, she would communicate that to her. RN-A stated she had not received any notification of bathing refusals by R30. During an interview on 12/6/23 at 8:36 a.m., the DON was informed of findings. The DON stated he thought it was a documentation issue, and that maybe R30 had been receiving bed baths,	F 677		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 15 however admitted there had been no documentation of any bathing and no refusals. The DON stated he expected residents to be bathed according to their preferences, and if they refused, staff should notify the nurse in charge. The facility Bath Services policy with revised date of 4/4/22, indicated to give bath or shower per resident preference on care plan or per resident request. Chart bath in POC bath task. Do not check off or erase name from bath section of the white board until bathing complete. If resident refuses, document rejection of care behavior and update staff nurse of refusal.	F 677		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to make an appointment for 1 of 1 resident (R44) reviewed for vision. Findings include:	F 685	Resident care coordinator scheduled an eye doctor appointment for resident # R44 for 12/12/2023 at resident's choice of a clinic (Blue Earth Valley Eye Clinic). On 12/7/2023 nursing and social worker education, for all residents regarding	1/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 685	Continued From page 16 R44's quarterly Minimum Data Set (MDS) assessment dated 11/15/23, indicated R44 had moderately impaired cognition, was dependent on staff for toileting, personal hygiene, required partial/moderate assistance with upper body dressing, adequate vision, and no corrective lenses, diagnoses included: dry eye syndrome and cerebrovascular disease (conditions that affect blood flow and the blood vessels in the brain). Care plan printed 12/6/23, indicated R44 has impaired visual function r/t (related to) hx (history) of CVA (cerebrovascular accident) and intervention included arrange consultation with eye care practitioner as required. Progress note dated 9/6/23 at 1:10 p.m., registered nurse (RN)-E indicated R44 was complaining about double vision and states that "We've" known about it for two years, writer explained that this was the first I had heard of it, but we could try to get her into her eye doctor to check her vision if she would like. Resident just stated that "something better be done." Progress note dated 9/7/23 at 3:36 a.m., licensed practical nurse (LPN)-F indicated R44 stated she continues with double vision, request to release information from ... (previous eye clinic) to eye clinic at (local eye clinic), once ... (local eye clinic) receives her information an appointment can be scheduled. On 12/4/23 at 1:38 p.m., R44 stated six months ago she told staff she had double and blurry vision and requested an eye doctor appointment. R44 stated she was told an appointment would be made but had not received any follow-up from	F 685	resident concerns that warrant an appointment, the education included that if there is a request of any type of need for an appointment, staff will notify resident care coordinator to assess and set up appointment. Staff are to leave a voicemail of concern to resident care coordinator who will then reassess (if necessary) and/or help set up a time for needed appointment, this will apply for all residents. All residents are at risk of need of an appointment, so Resident care coordinator will also review all charting to make sure no potential appointment needs are missed, during their quarterly look back period and as needed. This will be audited at resident's quarterly assessment, and prn as needed. All audits will be brought to QAPI for approval and completion when teams deem appropriate. All staff education on 1/4/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 685	Continued From page 17 staff on requests for an eye appointment. R44 stated she has glasses, but she did not wear the glasses because they did not help with her blurry vision. R44 stated she could not remember the staff member's name she had discussed her vision concerns with. On 12/5/23 at 10:26 a.m., registered nurse (RN)-C, stated she was the care coordinator for R44 and was not aware R44 had vision concerns and stated R44 had not brought the vision concerns to her during assessments or care conferences. On 12/6/23 at 10:43 a.m., RN-C was shown the progress note from 9/7/23, that identified R44's vision concerns and request for an eye doctor appointment. RN-C stated she had not been made aware of R44's request to see an eye doctor, and expected staff to make her aware so she could make the appointment, or would expect staff to make the appointment and address R44 vision concerns. On 12/6/23 at 11:30 a.m., during an interview the director of nursing (DON) stated when a resident requested an appointment he expected the facility would make the requested appointment for the resident and relay that information to the resident or give a status update if the appointment could not be made. The DON stated if a a resident had vision concerns would expect staff to follow up with the provider and expected R44 to have had an appointment for the eye doctor per her request. A policy or protocol for assisting residents with making appointments was requested however, the DON revealed the facility had none.	F 685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure weekly comprehensive skin assessments were completed for 1 of 3 residents (R27) reviewed for pressure ulcers Findings include: R27's quarterly Minimum Data Set (MDS) assessment dated 10/4/23, indicated R27 had severe cognitive impairment, dependent on staff with toileting, showers, dressing, personal hygiene, at risk for pressure ulcers, had one unhealed Stage II pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister.), and one unstageable - deep tissue injury; skin and ulcer/injury treatments included pressure reducing device for chair and bed, nutrition or hydration intervention to manage	F 686	RN-B and all nursing staff educated regarding timely wound care checks on 12/6/2023. R2's heels were assessed and documented on 12/6/2023. RN B will be audited by the Director of Nursing regarding pressure injuries and documentation. RN-B now has a backup system in place if she were to be gone, where the Resident care coordinators or MDS nurse would fill in for assessments. Wound care coordinator and/or nurse will document on wound in point click care EMR system via wound note or skin and wound digital wound assessment. All pressure injuries and/or ulcers will have a digital wound assessment with pictures taken weekly. All pressure injuries will be brought to weekly IDT or Nursing administration meetings for review, this will serve as a weekly audit for all residents who may have a pressure injury	1/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 19 skin problems, pressure ulcer/injury care applications of ointments/medications; diagnoses include stroke, stage II pressure ulcer of the left heel, pressure induced deep tissue damage of right heel and weight loss. R27's care plan printed 12/6/23, indicated potential/actual impairment to skin integrity r/t (related/to) fragile skin, hemiplegia, incontinence, limited mobility, 12/15/22, new pressure area to right heel, treatment in place and rounded on by WCC (wound care coordinator) and interventions included: 10/3/22, noted 5 c.m. (centimeter) x 5 c.m. dark purple spongy area to posterior left heel during cares, WCC updated, will assess and monitor per protocol, heel boots and floating initiated immediately upon discovery, 12/15/22, pressure area to right heel, float heels and blue boots when in bed, encourage good nutrition and hydration in order to promote healthier skin, follow facility protocols for treatment of injury, needs assist of 1-2 to turn and reposition every 2 hours and prn (as needed), needs total assist to apply protective garments (heel lift boots), needs pressure reducing cushion to protect the skin while up in chair, needs pressure reducing mattress to protect the skin while in bed, use a draw sheet or lifting device to move resident, weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations, identify/document potential causative factors and eliminate/resolve where possible, keep skin clean and dry, use lotion on dry skin ,do not apply on open areas, if present. R27's Medication Administration Record (MAR) dated 12/1/23-12/31/23, 11/1/23-11/30/23,	F 686	and or wounds. All residents are at are or who are at risk of skin break down, therefore, all weekly skin and wound audits by the nursing staff were reviewed by the resident care coordinator, to confirm no wound documentation is missing for any of our residents. All wounds will be reviewed with staff on Thursday staff huddles so all nursing staff are up to date on all wounds. All staff education on 1/4/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 20 10/1/23-10/31/23, and 9/1/23-9/30-23 indicated complete skin observation tool assessment weekly every evening shift every Fri (Friday) with a start date of 11/18/22. Progress note dated 12/4/23 at 10:33 p.m., by licensed practical nurse (LPN)-C indicated R27's heel bleeding when transferred to bed cleansed and Mepilex (absorbent foam dressing) applied R27 very aggressive with cares... Progress note dated 11/27/23 at 2:44 p.m., LPN-D indicated R27's heel looks good. Progress note dated 11/12/23 at 8:34 p.m., LPN-E indicated R27 treatment to left heel completed, discolored area that approximately an inch in length noted, old blood on old dressing, cleaned area with soap and water, dried, and applied a new dressing, skin on heel is dry and peeling. R27's wound evaluation dated 11/20/23, indicated left heel stage II pressure, improving, length 4.57 c.m. and width 4.21 c.m. and picture of the left heel on the document showed the heel was closed, reddened, and boggy. R27's medical record lacked evidence of weekly comprehensive skin assessments as ordered and outlined in the care plan since 11/20/23, that included measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate and any other notable changes or observations . On 12/5/23 at 10:16 a.m., nursing assistant (NA)-E stated R27 had wound on her left heel, and staff floated R27's heels when in bed and	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21 when she was in her wheelchair she wore cushioned boots to protect her heels. NA-E stated R27's heels were a problem area and would open up and then would close, and then open again. NA-E stated the NA's looked at R27's heels multiple times a day and were responsible to inform the nurse when the area was opened or changes. On 12/5/23 at 10:17 a.m., LPN-D stated R27 heels would heal and then break down again , and stated R27's heels were looked at least daily by staff, and currently the heels had Mepilex (absorbent foam dressing) put on for protection, and then lantiseptic (skin protectant) to the heels. LPN-D stated R27 heels were opened, after they had recently closed, which was nothing new for them to open up again. LPN-D stated she notified RN-B today (12/5/23) to look at R27's heels to see if there was a different treatment we could do, and stated RN-B had not looked at R27's heels yet today. LPN-D stated weekly RN-B was responsible for assessing R27's heels, that included pictures and wound orders if she changed the treatment. LPN-D stated she had not notified the provider of R27's heels that were now opened, and stated would expect RN-B to notify the provider as the wound nurse. On 12/5/23 at 10:27 a.m., RN-C, who was resident care coordinator stated R27 has had constant problems with her heels and at one point the heels were clearing up, but then they break down again and the process starts all over. RN-C stated RN-B assessed R27's heels weekly, heels were floated, and treatments daily. RN-C stated R27 has terrible intake and refuses her supplement which does not help the wounds.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 22 On 12/6/23 at 12:21 p.m., R27 was seated in a wheelchair at dining table with cushion boots on feet. On 12/6/23 at 12:25 p.m., during an interview RN-B and the director of nursing (DON) stated R27's heels breaks down due to comorbidities, decline in health and diet, and further stated staff closely watch R27's skin multiple times a day. RN-B stated R27's heels were assessed by her weekly when opened and then nursing staff were expected to monitor the heels if they skin was not opened. On 12/6/23 at 12:51 p.m., RN-B stated she created a document for residents that were due for weekly skin checks by herself, and stated had had not been able to complete R27's skin checks the last two weeks, as she was off work two weeks ago, and then had to help the facility due to RN-C being out last week. RN-B confirmed R27's last skin comprehensive skin with measurements was 11/20/23. On 12/6/23 at 1:13 p.m., R27's heels were observed with RN-B. RN-B removed a Mepilex off R27's left heel that was saturated with reddish brown drainage, the heal was opened, reddened, with bleeding. RN-B described the wound as a stage II pressure ulcer, and took a picture of the area and stated the picture would provide the measurement. R27's right heel had no dressing, and no opened areas the heel was observed with dark purple reddened area. R27 stated the heels only hurt when the bandage was taken off. RN-B stated on 12/4/23, LPN-D requested her to do wound care on R27 and she told LPN-D she did not have time. RN-B stated she was not aware the heel was opened until then.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 23 On 12/6/23 at 1:20 p.m., RN-C stated she was made aware on 12/4/23, R27's heel was opened again, and verified she would expect the area measured, and weekly skin checks done by RN-B. RN-C stated a skin check was signed off by LPN-D on 12/1/23, in the computer however RN-C could not find the documentation of the skin check in the computer. On 12/6/23 at 1:24 p.m., NA-E stated she completed R27's morning cares today and bandage was observed on R27's left heel. NA-E stated on 12/4/23, she assisted LPN-D, and the left heel was open and no drainage on the dressing, and on 12/5/23, when she assisted LPN-D with the dressing change there was drainage present. On 12/6/23 1:59 p.m., LPN-C stated she assessed R27's heels on 12/1/23, and the heels were reddened, and no opened areas and then she wrote her notes on her personnel resident care sheet and forgot to put the documentation in the computer or a resident document sheet to be scanned into the computer. LPN-C stated on 12/4/23, she observed R27's heels and the left heel was open, bleeding and painful , and applied barrier cream and covered the open area with a Mepilex. LPN-C stated she had not measured the area, however did write a note in the computer. LPN-C stated R27 has problems with her heels where they open and close, and staff watch the areas closely and provide treatments as ordered. LPN-C stated she would expect when the heels reopened the areas measured and description of the area documented. On 12/6/23 at 3:34 p.m., during a phone interview	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 24 nurse practitioner(NP)-D stated R27 has had heel wounds on and off, and stated the facility was expected to complete weekly comprehensive skin assessments that included measurements and description. On 12/6/23 at 3:35 p.m., the DON stated he would expect RN-B to assess R27's wounds weekly and staff were expected to assess daily, and would expect staff documentation anytime the wound was assessed. The DON stated if R27's heels were worsening would expect any nurse to measure and document on R27's heels and notify RN-B. The DON stated RN-B was expected to assess resident wounds when notified by a nurse that day or at the latest the next day, and would expect nursing to notify the provider when the wound has changed. On 12/6/23 at 3:46 p.m., RN-B stated had documented R27's heel as a stage II pressure ulcer, however now she is not sure if it was pressure and would contact the provider for clarification of the wound, and confirmed documentation of weekly measurements and a comprehensive description was expected when a wound was classified as a pressure ulcer. RN-B stated it was important to check R27' skin regularly since she was at risk for skin breakdown and already had a skin issue. RN-B's documentation of R27's wound on 12/623, indicated Stage II pressure ulcer 2.3 c.m. x 1.58 c.m. The facility Wound care nursing documentation policy dated 4/4/23, indicated Purpose: It is important to document wound healing. Identifying and assessing skin and/or	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 25 wound condition in a timely manner is key to effective treatment. Responsibility: RN, LPN Procedure.: Residents should have their skin monitored daily with cares/dressing change, weekly body audits with bathing and upon admission or readmission to the facility. Once an area has been observed under resident, the area needs to be evaluated by a licensed nurse. When able, the point click care digital wound management system should be used. 1. Location of the wound 2. Observe the color of the wound 3. Evaluate odor of wound 4. Evaluate level of moisture of wound 5. Evaluate wound exudates 6. Evaluate tissue viability 7. Evaluate peri wound condition 8. Evaluate extent of pain 9. Measure length and width of wound 10. Stage the wound 11. Describe the interventions 12. Notified primary care physician of findings and treatment requires per finds of wound. 13. Notify MD of any wounds that are not healing or showing signs of worsening in stages or signs of infection. 14. Ensure the resident is education on the need to utilize pressure reducing devices 15. Residents who have existing wound will be evaluated by the case manager for proper pressure relieving devices, turn and reposition schedule, nutritional interventions and proper education admissions, significant changes quarterly and with hospital readmissions.	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 26	F 689		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately assess and monitor ongoing safe smoking practices for 1 of 1 resident (R23) reviewed for smoking. Findings include: R23's Admission Record printed 12/6/23, included diagnoses of anxiety disorder, heart failure, end stage renal (kidney) failure dependent on renal dialysis, malignant neoplasm of transverse colon (cancer that begins in the last part of large intestine) and acquired absence of right leg above the knee. R23's quarterly Minimum Data Set (MDS) assessment dated 8/30/23, indicated R23 had moderate impairment of cognition. The MDS also indicated R23 required extensive assistance of one for activities of daily living (ADL's), and had lower extremity impairment on one side. R23's MDS question regarding tobacco use was not answered yes or no. Oxygen use was blank. R23's smoking assessment dated 6/13/23, indicated R23 utilizes tobacco with no concerns	F 689	Resident #R23 care plan was updated on 12/11/2023 with staff to help resident outside to smoke and to be placed near the ash tray, staff will also make sure she has the smoking pendant so she can notify staff when she is done. The staff Kardex was also updated on 12/11/2023. Staff member completed new smoking assessment on 12/11/2023. Staff educated on resident's smoking safety concerns on 12/11/2023. Staff educated on all smoking residents (no other current smokers at this time) to monitor for safety and update the care plan. Nurse who completed smoking assessment on 9/13/2023 was educated on 12/11/2023. Staff to complete audit when resident smokes for safety. Staff to bring audits to QAPI meeting for review and acceptance. All staff education on 1/4/2024.	1/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 27 identified with smoking safety evaluation except resident is to follow the facilities' policy on location and time of smoking. R23's smoking assessment dated 9/11/23, indicated the resident utilizes tobacco. Evaluation identified balance problems while sitting or standing, and drops ashes on self. Concerns identified unable to extinguish a cigarette safely and unable to use ashtray to extinguish a cigarette. Clinical suggestions was blank. R23's tobacco use care plan revised 9/13/23, included: R23 will adhere to the tobacco/smoking policies of the facility. Conduct smoking safety evaluation on admission and as needed. Education given on 9/13/23. Educate resident/responsible party on the facility's tobacco/smoking policies. Risk benefit for smoking completed 9/13/23. Smoking cessation reviewed and signed quarterly, completed 9/13/23. R23's activities of daily living (ADL's) plan of care printed 12/6/23, indicated the resident requires 1-2 assist with toileting, and extensive assist of 1-2 with EZ stand for transfers. R23's cardiovascular status indicated alteration related to hypertensive heart, chronic kidney with heart failure, chronic obstructive pulmonary disease... Interventions included oxygen as ordered. If oxygen applied, take off while resident is smoking outside. Can not have lighters in room if there is an oxygen tank. A provider order dated 7/20/23 indicated do not use oxygen unless oxygen saturation drops below 90% .	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 28 A progress note dated 6/23/23 at 1:44 p.m., by social services (SS)-A indicated R23 has not been complaint with her smoking in designated areas versus her bathroom. A call with a family member (FM)-C who buys her the cigarettes, was informed they need to be given to the nurse to keep on the cart as ashes were found this morning on her toilet seat. A staff member also reported a cigarette butt floating in her toilet. FM-C will make sure she does not have any cigarettes and since they buy them will give them to nurse when they deliver them. A progress note dated 8/25/23 at 4:00 p.m., by SS-A indicated staff shared that upon resident return from dialysis today, when cleaning R23's room, they could smell smoke in her bathroom and ashes were found in front of the toilet. A progress note dated 9/6/23 8:36 a.m., by director of nursing included "spoke with R23 regarding staff finding ashes on her bathroom floor. R23 denied stating "that can't be". Question if she puts her cigarette butts in her sweatshirt and she states yes. Asked why she does that and not throw them away and she indicated when she smokes here on campus she puts them in the disposal outside, but when she smokes at the hospital they don't have a container. She stated "I refuse to liter". R23 stated she often flushes the butts when she gets back. Encouraged resident to dispose of all butts outside in the disposal. R23 stated she will talk to the driver to have her dropped off closer to the disposal when she gets back." A progress note dated 9/13/23 at 3:36 p.m., by registered nurse (RN)-A indicated it was brought	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 29	F 689		

to her attention that the resident was inside bathroom with door closed. When NA tried to open the door, R23 stated to not come in. After resident was out of bathroom NA went into room and resident's room smelled like cigarette smoke. At care conference today, R23 signed risk benefit where it stated there should be no smoking inside building or in room. Smoking should be outside of facility by door 21. RN-A educated staff the next time resident is in bathroom staff need to open door for her safety.

Progress notes present for 10/6, 10/8, 10/10, 10/11 by environmental services indicating bathroom smelled of cigarette smoke in R23's room.

A progress note 12/4/23 at 2:37 p.m., by RN-A indicated R23 was willing to visit with the ombudsman. R23 denies she is smoking in the facility and goes independently or has staff assist her to the designated smoking area outside.

A progress note dated 12/5/23 at 11:57 a.m., by RN-A indicated she consulted about the note left by overnight staff with social worker, MDS coordinator and DON regarding having oxygen started in her room, if her oxygen saturation above 90% her oxygen needs to be removed per orders. Discussed that if resident has lighter and cigarettes in room, they need to be removed while oxygen is being used due to history of noncompliance with potential smoking.... Oxygen concentrator will be kept outside of room by the scale per ombudsman recommendation and safety protocol due to noncompliance with potential smoking in room."

During observation and interview on 12/4/23 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 30 2:54 p.m., R23 indicated she does smoke cigarettes but she only smokes when she goes outside. R23 stated "I keep my own cigarettes and lighter in my room." No cigarettes or lighter was seen in her room. The room did not smell like cigarette smoke. R23 indicated she returned from dialysis around 1:00 p.m. today. No oxygen was present in her room. A progress note dated 12/5/23 at 2:40 p.m., by RN-A indicated R23's room smelled heavily of smoke and was demanding her oxygen. R23 inquired why oxygen concentrator couldn't be kept in her room. RN-B reminded R23 resident couldn't keep it in room as it is suspected R23 may be smoking in her room. R23 stated no to smoking in her room stating "I don't even have any cigarettes." When asked if she could explain where the smoke is coming from, R23 stated "I don't know". R23 was educated on trying to keep her and all the building safe from something dangerous happening. During interview on 12/5/23 at 4:44 p.m., the administrator indicated they have placed extra smoke detectors that are supposed to alarm if cigarette smoke is detected in R23's room when staff began reporting smelling cigarette smoke in R23's room. The administrator indicated she has spoken with R23 four or five times about her potential smoking in the building and she has denied smoking cigarettes in her room. The administrator indicated she is concerned that when the facility takes her cigarettes and lighter to store at the nurses station, the family is bringing her more. The administrator indicated she feels comfortable that R23 will not smoke with oxygen in her room.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 31 During observation on 12/5/23 at 12:57 p.m., R23 was in dining room having lunch. Oxygen concentrator was outside of her room in alcove. During observation on 12/5/23 at 2:31 p.m., R23 was in her room with door closed. Did not answer knock on the door. Oxygen concentrator remained outside of her room. During interview on 12/5/23 at 2:34 p.m., licensed practical nurse (LPN)-B indicated R23 goes out to smoke and takes an SOS button and then calls when she is ready for staff to bring her back. LPN-B indicated until June 2023, R23 was able to wheel herself to the front lobby and outside to smoke herself but now requires assistance from staff. LPN-B stated she has not actually seen R23 smoking in her bathroom, but staff have smelled it and found ashes in her room along with cigarette butts in the toilet. LPN-B was unsure if R23 is able to safely smoke as she has never observed her smoking. LPN-B stated she has tried to take R23's cigarettes and lighter from R23's room but R23 refuses to give them to her. LPN-B added the family has been informed if providing cigarettes and lighter they are to be brought to the nurses station but doesn't believe that has been happening. During observation and interview on 12/6/23 at 8:04 a.m., licensed practical nurse (LPN)-A indicated R23 refused to go to dialysis this morning, stating she doesn't feel good enough to go. R23 declined to speak to surveyor and asked the door be closed. R23 had oxygen on and concentrator in the room. During interview 12/6/23 at 8:58 a.m., nursing assistant (NA)-B indicated she has smelled	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 32 cigarette smoke in R23's room multiple times with the last time about a month ago. NA-B indicated "she is apparently allowed to have her cigarettes and lighter in her room." NA-B denied every seeing cigarettes or a lighter in R23's room. During interview on 12/6/23 at 9:09 a.m., NA-A indicated approximately a month ago, she smelled cigarette smoke in R23's room. NA-A indicated R23 is not supposed to have cigarettes or a lighter in her room but R23 is not compliant with many rules. NA-A indicated R23 has not requested staff take her out to smoke in over a month. During interview 12/6/23 at 11:25 a.m., the DON indicated staff have reported smelling cigarette smoke in R23's room and "presume she is smoking in her room." The DON indicated he has spoken to R23 multiple times and she denies smoking in her room and states she doesn't have any cigarettes or lighters in her room. The DON indicated he has never smelled cigarette smoke in R23's room. Reviewed 6/23 and 9/23 smoking assessments with the DON and he stated "I don't believe that is an accurate smoking assessment" referring to 9/23 assessment and will request another smoking assessment to be completed. The DON added that could be difficult as she is no longer smoking at the facility per his conversation with R23. If the smoking assessment is accurate he would expect smoking interventions to be put into place for R23's safety. During interview on 12/6/23 at 12:11 p.m., family member (FM)-C indicated she has not provided any cigarettes or lighter for the past few months. FM-C indicated another family member brought her cigarettes two weeks ago but not a lighter.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 33	F 689		

FM-C indicated she could possibly have a lighter but family hasn't provided one.

During interview on 12/6/23 at 11:36 a.m., RN-A indicated based on the assessment that she completed on 9/11/23, she would expect interventions for safety with smoking would have been implemented. RN-A stated from her observation the assessment is accurate. RN-A indicated she has spoken with the administrator and DON multiple times regarding R23 and smoking in her room but could not find documentation the DON was notified in the change of smoking assessment. RN-A indicated she has had multiple reports from staff regarding the smell of smoke, ashes on or by the toilet and cigarette butts in the toilet. RN-D stated she has asked R23 multiple times if she has cigarettes or a lighter in her room and she has denied having them every time.

During interview on 12/6/23 at 1:05 p.m., NA-D indicated he has smelled cigarette smoke in R23's room multiple times and always reports it to the nurse. NA-D indicated he has never seen cigarettes or a lighter in R23's room but has been told she refuses to give them to staff.

During interview on 12/6/23 at 4:08 p.m., the DON indicated he had spoken to RN-B regarding the smoking assessment from 9/11/23 and after review indicated it is not accurate. The DON indicated at a minimum he would expect the smoking care plan would include the lighter and cigarettes to be kept at the nurses station.

During interview on 12/6/23 at 4:37 p.m., RN-B indicated after review of the smoking assessment for R17, she may have read the questions wrong.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 34 RN-B indicated R17 was able to use ash tray and extinguish the cigarette safely. The facility Smoking policy dated 1/2022, included: -Smoking is not allowed inside the facility under any circumstances. -Oxygen use is prohibited in smoking areas. - Staff shall consult with the attending physician and the DON to determine if safety restrictions need to be placed on a resident' smoking privileges based on the "Safe Smoking Evaluation". -A residents ability to smoke safely will be re-evaluated quarterly, upon a significant change and as determined by the staff. -Any smoking-related privileges, restrictions, and concerns shall be noted on the care plan, and all personnel caring for the resident shall be alerted to these issues. -Residents who have independent smoking privileges are permitted to keep cigarettes, pipes, tobacco, and other smoking articles in their possession, unless's otherwise care planned. -Residents without independent smoking privileges may not have or keep any smoking articles, including cigarettes, tobacco, etc., except when they are under direct supervision. -The facility maintains the right to confiscate smoking articles found in violation of our smoking policies.	F 689		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and	F 692		1/15/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 35 enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively reassess and develop interventions to reduce/prevent continued weight loss for 1 of 1 resident (R7) reviewed for weight loss. Findings include: R7's face sheet printed on 12/6/23, included diagnoses of fracture of the acetabulum dome (a break in the hip socket) on left hip, Parkinson's disease and dementia. R7's significant change Minimum Data Set (MDS) assessment dated 9/1/23, indicated R7 had severely impaired cognition, clear speech, could understand and be understood. R7 required extensive assistance from one staff for all activities of daily living (ADL's) except eating in which he required supervision.	F 692	Resident #R7 weights were assessed by dietary manager. We are offering him honey nut cheerios w/Peanut Butter Toast or Grilled Cheese & Tomato Soup at dinner and supper because those are his 2 favorite meals. For a snack we are giving him a chocolate peanut butter shake @ 1pm then giving him ice cream with chocolate syrup at supper. Going to monitor weights weekly. Since we have started the meal change, he has been having better intakes at Dinner and Supper. During weekly weight audits at interdisciplinary meetings staff will not only look at recent weight trends but will include significant weight changes going back 6 months for all residents, with an emphasis of at risk. To protect all residents who are at risk or trending	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 36 R7's care plan printed on 12/6/23, indicated R7 had a nutritional problem related to chronic diagnoses, his dentures were loose due to weight loss, and intake was variable. Interventions included use of a lip plate, 120 ml (milliliters) of supplement of choice once daily, to monitor intake and record every meal. R7's physician orders dated 6/8/23, included consistent carbohydrate diet, regular texture, thin consistency. Standing orders from 6/8/23, included: 1) Changes in food consistency may be initiated without a physician's order at the discretion of nursing and/or dietary. Physician order will be requested within 10 days if the texture change remains appropriate and 2) Supplement of choice 120 ml everyday in the morning for supplement. During record review, it was noted R7 was admitted to the facility on 6/8/23. On that day, R7 weighed 205.5 pounds and on 12/3/23, weighed 177 pounds, which was an almost 14% weight loss, or 28.5 pounds. A progress note dated 8/31/2023 at 10:50 a.m., written by registered dietician (RD)-G indicated according to the Quarterly Review for Nutrition dated 8/23/23, R7 was able to make his own food choices known and denied having any chewing or swallowing concerns. According to eating records in Point Click Care (PCC), R7 was able to feed himself. The RN case manager reported family member (FM)-E had stated she thought R7's loose dentures were affecting how much he ate. R7's weight had previously stayed stable within several pounds either side of 200 pounds during his last admission January to March 2022. R7's	F 692	towards a weight loss or/gain, the dietary manager and Dietitian will look at caloric intake and food interventions/preferences. Weight change note will then be added by team member to allow an audit trial. IDT staff education on 12/7/2023. All staff education on 1/4/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 37 weight on this admission was 205.5 pounds and was now down to 183.5 pounds. R7 continued with orders for 120 ml supplement of choice once daily in the morning. RD-G spoke to RN case manager and recommended that he be evaluated to see if there is a more appropriate food texture for him, due to the recently noted delayed swallowing and his poor fitting dentures which were likely affecting his food intake. Also recommended increasing his supplement to BID (twice a day). (During record review, an order to increase supplement to BID had not been obtained). Progress note dated 8/31/2023 at 11:30 a.m., written by RD-G indicated: Dietary manager (DM)-A reported to me after I completed my progress note that R7 had past been resistant to altered texture food, also that plans were to mix a protein powder into ice cream, which was his favorite snack. Dietary will talk with nursing about getting an order for the protein powder. (Upon record review, an order for protein powder had not been obtained). During a telephone interview on 12/6/23 at 11:29 a.m., RD-G stated she worked 20-25 hours per month for the facility, so unless staff told her a resident had a new issue, she did not get involved. RD-G stated at her recommendation the facility started a weekly IDT (interdisciplinary team) meeting for residents with weight loss. RD-G suggested speaking to DM-A who brought weight loss concerns to the IDT meeting. RD-G she wouldn't have been involved unless IDT referred R7 to her. During an interview on 12/6/23 at 12:00 p.m., DM-A stated was aware of R7's weight loss and	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 38 stated he had been discussed at the weight loss IDT meeting. DM-A stated they had tried different things to reduce or prevent continued weight loss such as adding cheese to R7's scrambled eggs, putting peanut butter on his toast, and extra butter in his pasta and potatoes. DM-A stated R7 didn't like to drink nutritional supplements and they had considered adding protein powder to his ice cream but had not yet, despite being an option identified in August. When asked to see discussion notes from the weight loss IDT meeting, DM-A stated she didn't have any notes. Other than cheese, peanut butter and extra butter, DM-A could not identify what had been tried, what had worked and what had not worked. At 12/6/23 at 12:10 p.m., DM-A added RD-G to the conversation via telephone. RD-G guided DM-A to look in the computer for DM-A's notes regarding R7, explaining there was a sheet for each unit which included resident allergies, food likes and dislikes. The only notes listed on this sheet for R7 had been to add cheese to scrambled eggs. RD-G informed DM-A that something needed to be documented in a progress note, such as what's working, what's not working, and what you plan to continue...something that says this is our game plan. RD-G informed DM-A she should have a short list of residents who she monitored for weight loss. RD-A stated DM-A, nurse practitioner (NP)-F and her had been trying to get together to address weight loss strategies for R7 but had not met yet. During a telephone interview on 12/6/23 at 12:40 p.m., FM-E stated she took R7 to the dentist and they fixed his dentures, but now he had lost too much weight for them to fit properly. FM-E stated she was told it would cost $2000 to fix the	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 39 dentures, but they didn't have that to spend. FM-E stated the facility had run out of Poligrip (denture adhesive) a while ago and due to a Covid outbreak, FM-E had not been at the facility to know if staff were putting adhesive on R7's dentures. During an interview on 12/6/23 at 2:08 p.m., the director of nursing (DON) was informed of findings. The DON accessed R7's electronic medical record (EMR) and stated there had not been an automatic trigger warning for weight loss. The DON acknowledged it might not trigger for a gradual weight loss. The DON located IDT meeting notes from 12/5/23, which showed R7 had one pound weight loss over two weeks. The notes did not identify R7's total weight loss of 28.5 pounds since admission five months ago, nor did it include a plan of action. The DON stated R7 had Parkinson's disease and since Covid outbreak, FM-E had not been coming over for meals which might effect R7's intake. When asked if the provider had been made aware of the weight loss, the DON stated the provider had been given a visit prep note about the weight loss, but there had not been a corresponding visit note indicating her awareness or new orders related to weight loss. The DON acknowledged he would expect a significant weight loss to be comprehensively evaluated and addressed for interventions to reduce and prevent continued weight. During a telephone interview on 12/6/23 at 3:34 p.m., NP-D stated she had been aware R7 had lost weight, but not anything specific; she had not noticed trends. NP-D stated R7 had Parkinson's disease and dementia and did not always want to eat. NP-D stated RD-G and her had	F 692		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 692	Continued From page 40 conversations about resident weight loss in general, including R7, but wouldn't have documented that. NP-D stated there were plans to meet with DM-A and RD-G to discuss resident weight loss. NP-D stated weight loss was expected for R7's disease and would expect the facility to make attempts to try different interventions, to monitor his weight and to document progress. The Facility Weight Monitoring - Nursing Services policy with revised date of 8/28/23, indicated the facility monitored resident weights from the time of admission and to provide interdisciplinary support and or intervention to avert adverse trends. The dietary department would complete a thorough assessment of the residents nutritional status. The dietary manager would evaluate weight changes weekly and report to IDT. Based on the outcome of the thorough assessment, information would be provided to the provider for decisions regarding the need for daily, or weekly weights and other interventions as appropriate.	F 692		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 695	R501's oxygen tubing and bubbler were	1/10/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 41 review, the facility failed to ensure oxygen tubing was changed and dated timely, and failed to create a comprehensive plan of care for oxygen therapy for 1 of 2 residents (R50) reviewed for respiratory care. Finding include: R50's admission Minimum Data Set (MDS) dated 8/19/23, indicated R50 was cognitively intact, required set up assistance with bed mobility, transfer, eating; required one person physical assist with dressing, toilet use, and personal hygiene, utilized a walker and wheelchair, diagnoses included respiratory failure and indicated R50 used oxygen therapy. R50's care plan dated 8/15/23, indicated R50 had altered cardiovascular/respiratory status and intervention included monitor/document/report as needed any changes in lung sounds on auscultation (example crackles), edema and changes in weight, respiratory monitoring per facility protocol and did not address oxygen use. R50's record review failed to indicate R50's oxygen tubing or oxygen humidification bottle (bubbler) had been replaced. During observation on 12/4/23 at 2:32 p.m., R50 was seated in her wheelchair with a nasal cannula in her nose connected to a liquid oxygen tank with a humidification bottle (bubbler). The liter flow rate was set to one and half liters per minute (LPM) and the humidification bottle and tubing was undated. R50 stated she was not sure if the oxygen tubing was changed on a regular basis, and stated last week she notified staff she was not getting air through her oxygen tubing and	F 695	labeled on 12/4/2023. Oxygen policy updated on 12/7/2023 to include oxygen tube labeling. This now indicates that all oxygen tubing, mask and bubbler should be labeled and changed every week. All Oxygen tubing, masks and bubblers were labelled on 12/4/2023. Tar “tasks” have been created to trigger every week for tubing. Mask and bubbler change and labeling. Nursing administration will audit all residents who utilize oxygen tubing/bubbler and mask to verify all residents have proper labeling. Nursing staff have developed a supply cart with labels, and tubing supplies for easy access to what they need when changing out products. All nursing staff educated on 12/7/2023. Staff will audit oxygen tubing every week for 2 months then monthly until approved by QAPI team. All staff education on 1/4/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 42 staff found the oxygen tubing was cracked, R50 stated staff replaced the oxygen tubing and R50 further stated she was not sure if staff had replaced the tubing previously. During observation on 12/5/23 at 9:47 a.m., R50 was observed wearing oxygen via nasal cannula, seated in her wheelchair in her room. The oxygen tubing and humidification bottle remained unlabeled and undated. During an interview on 12/5/23 at 9:52 a.m., registered nurse (RN)-D stated the oxygen tubing was expected changed weekly, and would expect the the bubbler bottle on the oxygen labeled, observed R50's oxygen tubing and humidification bottle with RN-D and she confirmed neither were labeled. RN-D stated the task was expected in the computer system for nursing to sign off on weekly. On 12/6/23 at 7:59 a.m., RN-C, who was known as the care coordinator for second floor, stated oxygen tubing was expected labeled with the date it was changed, and oxygen tubing was expected changed weekly and the bubbler was expected labeled and changed every two weeks. RN-C stated the task was expected on the treatment administration record (TAR), and was responsibility of the nursing staff. RN-C stated the nurse who enters the oxygen orders was responsible for putting in the orders in the computer on the TAR and stated there is an admission check list that instructs the admission nurse to enter tubing change weekly and bubbler change every two weeks. RN-C stated R50 was expected to have oxygen addressed on her care plan.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 43 On 12/06/23 at 11:28 a.m., the director of nursing (DON) stated the oxygen tubing was expected labeled and changed weekly, and stated would expect the care plan to address oxygen for R50. The DON stated the facility policy did not address the changing of the tubing weekly however it was a facility expectation.	F 695		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to identify and date facility-made frozen soups stored in 4 of 4 kitchenettes, and failed to ensure dishes in the kitchen were stored dry. This had the potential to affect all 61 residents who resided in the facility.	F 812	Failure to identify and date facility-made frozen soups stored in 4 of 4 kitchenettes: Containers of soup were immediately dated on day of finding, and all staff were given the current policy to read; policy was also posted on day of finding. Dating and labeling will be reviewed at the Dietary	1/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 44 Finding include: During an observation on 12/6/23 at 9:58 a.m., observed full-sized refrigerators in each kitchenette on each of four resident units. Observed in each freezer were multiple half-pint, plastic containers of an unknown food. The containers had not been labeled with contents, nor dated. During an observation and interview on 12/6/23 at 10:40 a.m., in the kitchen, dietary manager (DM)-A picked up clean metal steam table pans that had been stacked one on top of another on a wire rack. DM-A picked up two pans that were wet inside and one pan that had dried food on it. DM-A gave all three pans to the dishmachine worker to redo and asked another dietary worker to check all pans to ensure they were clean and dry. During the same interview, DM-A was informed of frozen containers of food on the units not being identified or dated. DM-A had not been aware of that and stated they were soups and should have been identified and dated. During an interview on 12/6/23 at 12:20 p.m., DM-A stated the frozen plastic containers contained homemade soup for the always available menu. DM-A stated the soup was good for three months and staff had begun labeling and dating the containers. The facility Infection Control policy, undated, indicated foods would be clearly labeled and dated in the freezer. All dishes, silverware, etc., would be stored cleaned, dry, and upside down on storage shelf.	F 812	Meeting on 1-3-24 by the Dietary Director. If any staff member absent from that meeting he/she will meet individually with Dietary Manager by 1-5-24. Kitchen Manager will audit all freezer items weekly for dates. This will be ongoing and added to Kitchen Manager job description. QAPI will review at first 2024 quarterly meeting. The facility failed to ensure dishes in the kitchen were stored dry: On day of finding a sign was immediately posted to remind dishwashers that they must check each pan to assure it is dry. On 12-12-23 Dietary Director and Kitchen Manager developed a new protocol for pans to be placed at an angle on the drying shelf, added an additional drying cart, and reviewed new protocol with staff. This new protocol will be reviewed again at 1-3-24 dietary staff meeting. The pans will be audited daily by the lead cook until 1-31-24 to assure new method being followed. Audits will be reviewed by QAPI at first 2024 meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880 SS=F	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 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:	F 880		1/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 46 (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 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 follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines to prevent the spread of Covid-19 when during a Covid-19 outbreak, failed to ensure appropriate use of personal protective equipment (PPE) when staff were observed not an wearing N-95 mask in the room of 1 of 1 resident (R51) in transmission based precautions (TBP) for Covid-19; failed to doff (remove) PPE per guidelines with staff were	F 880	On 12/4/2023, Housekeeper A, NA-C and NA-A were all educated by Infection control nurse regarding proper donning and doffing of PPE. On 12/7/2023 all nursing staff and staff members who entered resident rooms were supplied education on proper donning and doffing of PPE for Covid-19 droplet isolation. On 12/5/2023 all covid door signs were changed to the proper Droplet precautions signs for Covid-19. On 12/5 front desk	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 47 observed removing all PPE including N-95 masks prior to exiting the room of residents in TBP for Covid-19 for 4 of 4 residents (R51, R53, R29, R30); failed to ensure precautions posted on resident room doors (R51, R34, R29, R53, R211, R43, R22, R30, R159 and R160) were consistent and followed CDC recommendations; failed to ensure all staff were fit-tested for use of N-95 masks or respirator use for 3 of 3 employees (HSK-A, LPN-C, NA-C); failed to ensure masking occurred in public areas of the facility; and failed to ensure Covid-19 testing on residents was completed in private for 3 of 3 residents (R17, R42, R35). In addition, staff failed to wear gloves when handling food for 1 of 1 resident (R17). This had the potential to affect all 61 residents who resided in the facility. Finding include: Upon arrival to the facility on 12/4/23 at 11:30 a.m., a sign on the entrance door indicated masks were required and the facility currently has 14 cases of Covid-19. During the entrance conference, the director of nursing (DON)confirmed the facility was in Covid-19 outbreak status with 10 current residents and 4 staff members. During an observation and interview on 12/4/23 at 12:44 p.m., housekeeper (HSK)-A exited R51's room who was on TBP for Covid-19 with gown, gloves, face shield and regular face mask on. HSK-A discarded her gown in her trash bin on her cleaning cart. HSK-A then removed her face shield setting it face down on the top of her cleaning cart and then discarded it in trash basin on her cleaning cart. Removed her gloves and performed hand hygiene. Did not clean the top of	F 880	staff educated on the need to wear masks in non-resident areas due to outbreak testing along with all visitors upon entry to the building. Infection control nurse will perform Audits on isolation rooms for proper PPE weekly and will bring to QAPI meeting for review and acceptance. Fit testing medical forms have been given to employees to complete and hand them back in for Medical Director review and then will be fit tested. Education to infection control nurse on 12/6/2023 regarding to not test in dining rooms or public areas for covid-19. Audits will be completed on proper isolation door signage on all covid-19 isolation rooms. Covid-19 Testing location audits will be completed by the DON and brought to QAPI for review and acceptance prior to stopping audits. All staff trained on 1/4/2024 on proper donning and doffing of PPE in covid-19 isolation rooms, all staff educated on 1/4/2024 in regard to insuring proper signage for droplet precautions for all covid-19 isolation rooms. All staff education on 1/4/2024 on purpose and need for proper fit testing. DON has received orders that RN can start fit testing all staff that do not have any contraindications or concerns identified in their OSHA medical form, that were given to all staff. All staff with concerns or contraindications will be addressed by the medical director. The facility will start with direct staff for fit testing and work through all departments within the facility as needed. DON will use a staff list to monitor that all fit testing gets done. Staff member “NA-A” Educated on 12/6/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 48 the cleaning cart. Did not change her medical grade face mask. HSK-A indicated today is her first day on this pod and she wasn't aware she needed to wear an N-95 mask to enter R51's room. HSK-A indicated she normally takes her PPE off in the room but since she was finished cleaning the room decided to take it off outside the room instead of re-entering the room. HSK-A indicated she did do training on the computer for proper use of PPE when she started. HSK-A stated she has not been fit tested for respirator or N-95 mask. During observation and interview on 12/4/23 at 12:44 p.m., nursing assistant (NA)-C donned PPE including an N-95 mask and a took a paper sack with and entered R53's room who was in TBP for Covid-19. At 12:48 p.m., NA-C exited the room with no PPE on, completed hand hygiene and placed a new medical grade mask on. NA-C indicated they put their face shield and N-95 mask in a paper sack to save for use later and left them in R53's room. During an observation on 12/04/23 at 12:45 p.m., observed (NA)-A enter R30's room who was in TBP for Covid-19, wearing full PPE to deliver a meal tray. A few minutes later, NA-A exited R30's room with no PPE on, including her N95 mask. During observation and interview on 12/4/23 at 1:40 p.m., licensed practical nurse (LPN)-C donned PPE including N-95 mask and entered R29's room. LPN-C exited the room at 1:42 p.m. with no PPE on. LPN-C completed hand hygiene and placed a new medical grade face mask on. LPN-A indicated they do not reuse N-95 masks or face shield as they have adequate PPE supply and they discard all PPE inside the residents	F 880	on proper handling of resident food. All nursing staff education on when to wear gloves whilst feeding a resident was completed on 12/7/2023 all staff educated as to inform staff on any resident that needs feeding. Audits will be completed by the dietary manager regarding proper feeding techniques of staff for resident feedings. All staff will be updated on 1/4/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 49 rooms prior to exiting. During observation and interview on 12/4/23 at 4:56 p.m., LPN-C donned PPE and entered R53's room. A paper sack was present on the counter inside R53's room with N-95 mask and face shield present. At exit, LPN-C discarded gloves, gown, face shield and N-95 mask into waste basket then exited the room and completed hand hygiene. LPN-C indicated she was told to discard all PPE inside the room before exiting and pointed out the sign on R53's door that stated "Please remove your PPE before leaving the room". LPN-C indicated she has not had any fit testing since starting at the facility over two years ago. Despite CDC recommendation to remove N95 masks after exiting a room, R53, and R30's door had a facility-made sign, yellow in color and laminated that read: remove your PPE before leaving the room. During observation the following rooms had the following signs posted on their door: Room 103, R34: No sign on door (tested positive for Covid-19 12/1/23) Room 107, R29: Droplet precautions and donning and doffing for confirmed or suspected Covid-19. (tested positive for Covid-19 11/27/23) Room 109, R53: Droplet precautions and please remove your PPE equipment before leaving the room. (tested positive for Covid-19 11/17/23) Room 111, R51: Droplet precautions (tested positive for Covid-19 11/24/23) Room 121, R159: Droplet precautions and please see nurse before entering (tested positive for Covid-19 11/27/23) Room 120, R160: Droplet precautions (tested	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 50 positive for Covid-19 11/30/23) Room 125, R30: Droplet precautions and please remove your PPE equipment before leaving the room (tested positive for Covid-19 11/27/23) Room 126, R22: Droplet precautions and sequence for donning PPE equipment (tested positive for Covid-19 11/24/23) Room 129, R43: Droplet precautions and please remove your PPE equipment before leaving the room (tested positive for Covid-19 11/27/23) Room 134, R211: Droplet precautions and please remove your PPE equipment before leaving the room and sequence for donning PPE equipment (tested positive for Covid-19 12/3/23. The resident rooms had "Droplet Precautions" signs on all above doors except Room 103 which had no sign present. The "Droplet Precautions" signs indicated all PPE will be discarded prior to exiting the room, including N-95 mask or respirator. In addition, rooms 109, 125, 129 and 211 had yellow laminated facility made signs indicating to remove all PPE prior to exiting the room. During observation and interview on 12/5/23 at 9:43 a.m., NA-C donned PPE, placed his medical grade face mask in a paper sack and left it on the isolation cart and entered R53's room. NA-C exited the room with gloves on, face shield and N-95 mask on. Discarded gloves, face shield and N95 mask and placed in a paper sack outside of the room, completed hand hygiene and placed on new medical grade face mask. NA-C indicated he will dispose of the paper sack in a garbage can at the nurses station. NA-C indicated he had training for infection prevention and PPE use on the computer. He also followed another	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 51 employee and learned how to don and doff (take off) PPE from other staff members. NA-C indicated he has not had fit testing to wear N-95 mask or respirator. During observation on 12/5/23 at 10:07 a.m., an unidentified visitor entered the facility lobby without a mask and spoke to the receptionist (R-H) who had her facemask below her chin. Visitor was not requested to wear a face mask. Visitor was directed to and entered social services office and continued with no face mask on. During observation on 12/5/23 at 10:12 a.m., two unidentified employees entered the lobby and at reception desk without a facemask. One employee put on a face mask and spoke with R-H. R-H continued with mask below her nose and mouth. The second employee went into an office behind reception desk without face mask on. Two unidentified adult visitors entered the lobby with strollers with 3 children. The adult visitors were not wearing a facemask and no request was made for them to wear a face mask. The visitors left at 10:18 a.m. During observation on 12/5/23 at 10:15 a.m., maintenance staff (M)-A was in facility lobby with no face mask on. M-A indicated staff were not required to wear a mask in the lobby area; only in patient care areas. During interview on 12/5/23 at 10:16 a.m., registered nurse (RN)-B, also identified as infection preventionist, indicated at a meeting with other infection prevention team members, it was determined wearing a facemask was not required in the public lobby area even during a Covid-19	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 52 outbreak but was required once you entered the pods (resident care areas). RN-B added in hind sight, residents do wait in the lobby waiting for transportation at times but are always wearing a face mask or PPE if positive for Covid-19. RN-B reviewed signs on resident doors listed above and stated "the signs are confusing." RN-B stated a "droplet precautions" sign should be on each door along with donning and doffing PPE instructions. RN-B, after reviewing current CDC guidelines for PPE use for Covid-19, confirmed doffing should include removing PPE in the resident room but should remove N-95 mask or respirator once exiting the room. RN-B also confirmed everyone entering public areas should be wearing a medical grade face mask. During an observation and interview on 12/05/23 at 11:41 a.m., NA-A and (NA)-F stated they were instructed to remove all PPE prior to exiting a residents room who was in TBP for Covid-19, including their N95 mask. In addition, both NA's stated they had not been fit-tested for N95's at this facility. During interview on 12/6/23 at 10:22 a.m., RN-B confirmed housekeeping is required to wear N-95 face masks in Covid-19 positive rooms and following donning and doffing procedures for PPE. RN-B confirmed the facility has never done fit testing for staff to wear N-95 masks or respirators. RN-B added they have not had cooperation from the medical director for medical clearance required prior to testing. RN-B indicated time is a factor also as it takes 1/2 hour per person and there are 100 employees. Covid testing in public:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 53 During observation on 12/6/23 at 8:37 a.m., RN-B was going into resident rooms testing for Covid-19. RN-B then went to the dining area on the 1st floor, red pod and swabbed R17's, R42's and R35's nostril for testing for Covid-19 while residents were in the dining area eating. During interview on 12/6/23 at 10:22 a.m., RN-B indicated residents have never complained about being tested for Covid-19 in the dining area and she has been doing it that way for a long time. The facility PPE policy last reviewed August 2023 included: - PPE consists of items such as a face mask or shield, gloves, gown and/or goggles which are to be worn whenever there is a risk of contamination by the resident's blood or body fluids. It is a component of Standard Isolation precautions as well as part of additional isolation protection if a resident needs Contact, Droplet or Airborne Isolation for infectious issues. -See separate Centers for Disease Control poster for proper donning and removal of all PPE. Copies of this poster are provided on all isolation carts. See separate listing for tasks that require PPE to be worn. -Doffing poster included: except for respirators, remove PPE at doorway or in anteroom. Remove respirator after leaving patient room and closing the door. Food handling: During observation on 12/6/23 at 8:31 a.m., R17 was sitting in a wheelchair in dining room when NA-A approached to assist and picked up toast with ungloved hands and gave R17 a bite and set toast back on plate. NA-A again picked up toast	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	C 12/06/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 54 and gave R17 another bite at 8:32 a.m., with ungloved hands. At 8:33 a.m. NA-C left and went to a closet by the nurses station and returned with gloves on her hands and continued to assist R17 with his toast. During interview on 12/6/23 at 10:45 a.m., registered nurse (RN)-B indicated she had observed NA-A touching R17's food at breakfast this morning. RN-B stated she should not be touching anyone's food with her bare hands. During interview on 12/6/23 at 4:08 p.m., the director of nursing (DON) confirmed staff should not pick up food with their hands unless wearing gloves. The facility Feeding the Resident (dependent eating) procedure undated included: - observe universal precautions or other infection control standards as approved by appropriate facility committee.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **03 - LAKEVIEW METHODIST NEW** B. WING _____	**12/05/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/5/2023. At the time of this survey, Lakeview Methodist Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION	K 000		

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

Electronically Signed | 01/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **03 - LAKEVIEW METHODIST NEW** B. WING _____	**12/05/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Lakeview Methodist Healthcare Center is identified as Building 03 for this survey. It was constructed in 2021, is two-story, with a basement, is fully fire sprinkler protected and is of Type II(111) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **03 - LAKEVIEW METHODIST NEW** B. WING _____	**12/05/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 corridors which is monitored for automatic fire department notification. The building has automatic smoke detection in all Patient Rooms. The facility has a capacity of 72 beds and had a census of 61 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=D	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2 hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed test emergency lights per NFPA 101 (2012 edition), Life Safety Code section 19.2.9.1. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 12/5/2023 at 10:20AM, it was revealed by a review of available documentation that there was no inspection report stating the annual 90 minute test had occurred. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 291	A review of the procedure has been completed with those who do the checks of all types. The yearly 90-minute test was heavily stressed. Completed on 12/8/2023. All staff education on 1/4/2024.	1/4/24
K 918 SS=E	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 918		1/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **03 - LAKEVIEW METHODIST NEW** B. WING _____	**12/05/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 3 Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to inspect the emergency generator on a weekly basis per NFPA 99 (2012 edition), Health Care Facilities Code,	K 918	Meetings and re-training on all types of generator checks have been done. The meeting talked about the reason for checking and consequences for missing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **03 - LAKEVIEW METHODIST NEW** B. WING _____	**12/05/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 918	Continued From page 4 sections 6.4.4, 6.5.4, 6.6.4, NFPA 110, NFPA 111, and NFPA 70 section 700.10. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 12/5/2023 at 11:00AM, it was revealed by a review of available documentation that a weekly generator inspection had not taken place during the following weeks: 3/6/2023, 4/3/2023, 6/5/2023, 6/26/2023, 7/3/2023, 7/11/2023, 7/31/2023, 9/4/2023, 10/2/2023 and 11/6/2023. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	Completed on 12/8/2023. All staff education on 1/4/2024.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than	K 923		1/4/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **03 - LAKEVIEW METHODIST NEW** B. WING _____	**12/05/2023**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 5 or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain correct oxygen cylinder storage per NFPA 99 (2012 edition), Health Care Facilities Code, sections 11.3.1, 11.3.2, 11.3.3, 11.3.4, and 11.6.5. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 12/05/2023, at 10:30 AM, it was revealed by observation that in B13 O2 Storage Room, there was mixed storage of empty/full cylinders. There was no identified storage areas for full and/or empty cylinders. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 923	Empty and full takes are fully separated, and signs are up in place showing where each tank should be placed. Completed on 12/13/2023. All staff education on 1/4/2024.	