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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Q5B7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00451

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

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

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/12//2020** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **46** (L18)
13.Total Certified Beds **46** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 10/16//2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 10/14/2020 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 16, 2020

CMS Certification Number (CCN): 245374

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

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective October 10, 2020 the above facility is certified for:

46 Skilled Nursing Facility/Nursing Facility Beds

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

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered via Email
October 16, 2020

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

RE: CCN: 245374
Cycle Start Date: August 20, 2020

Dear Administrator:

On October 12, 2020, the Minnesota Departments 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.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Q5B7

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(L3) **LAKESIDE MEDICAL CENTER**
(L4) **129 EAST 6TH AVENUE**
(L5) **PINE CITY, MN** (L6) **55063**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/20/2020** (L34)

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2 AOA 3 Other

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Compliance Based On:
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And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 09/29/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 11/05/2020 (L20)

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

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X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
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27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
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03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
September 9, 2020

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

RE: CCN: 245374
Cycle Start Date: August 20, 2020

Dear Administrator:

On August 20, 2020, 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" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Teresa Ament, Unit Supervisor
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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 November 20, 2020 (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 February 20, 2021 (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:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 8/17/20, through 8/20/20 , during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years (annually for LTC).] At a minimum, the policies and procedures must address the following:] [(2) or (1)] A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of	E 018		10/10/20

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

Electronically Signed | 09/17/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	C 08/20/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 018	Continued From page 1	E 018		

the receiving facility or other location.

*[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures.
(ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of assistance.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 018	Continued From page 2 needs of the patients. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the facility emergency preparedness plan (EPP) included a procedure for tracking staff in the event of an emergency. Findings include: A review of the facility EPP revealed the plan lacked a procedure for tracking staff in the event of an emergency. On 8/20/20, at 3:15 p.m. the environmental supervisor verified the EPP lacked a procedure for tracking staff in the event of an emergency.	E 018	Staff tracking form was created and added to the Emergency Preparedness Operation Plan 9/15/20. Jaime Burg performed this correction. The staff tracking sheet will be audited x2 for 3 months, then monthly x3 month and then quarterly or until 100% compliance is reached. DON/ ADON or designee will monitor to ensure compliance and results will be reviewed at the QA/ QAPI meetings.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) *[For RNCHI at §403.748, ASCs at §416.54, HHAs at §484.102, CORFs at §485.68, OPO, "Organizations" under §485.727, CMHC at §485.920, RHC/FQHC at §491.12, ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required	E 039		10/10/20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	C 08/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 039	Continued From page 3	E 039		

community-based or individual, facility-based functional exercise following the onset of the actual event.

(ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,

clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed.

*[For Hospices at 418.113(d):]
(2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following:

(i) Participate in a full-scale exercise that is community based every 2 years; or

(A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or

(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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E 039	Continued From page 4	E 039		

scale community-based exercise or individual facility- based functional exercise following the onset of the emergency event.

(ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d) (2)(i) of this section is conducted, that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated,

clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or

(B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an additional annual exercise that may include, but is not limited to the

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E 039	Continued From page 5	E 039		

following:

(A) A second full-scale exercise that is community-based or a facility based functional exercise; or

(B) A mock disaster drill; or

(C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

(iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed.

*[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):]
(2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following:

(i) Participate in an annual full-scale exercise that is community-based; or

(A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or

(B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event.

(ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the

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E 039	Continued From page 6 following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following:	E 039		

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E 039	Continued From page 7 (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or	E 039		

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E 039	Continued From page 8 (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and documentation, the facility failed to ensure a second table top exercise or full-scale exercise for emergency preparedness was completed in the past year.	E 039	Full scale active shooter drill was exercised on 9/16/20 and then will be scheduled for biannual disaster drill or table top. A second drill/ table top will be	

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E 039	Continued From page 9 Findings include: A review of the facility emergency preparedness plan (EPP) and documentation indicated the facility lacked completion of a table top exercise or full-scale exercise in the past year, other than the COVID-19 plan and implementation. On 8/20/20, at 3:15 p.m. the environmental supervisor verified the facility lacked completion of a table top exercise or full-scale exercise in the past year, other than the COVID-19 plan and implementation.	E 039	scheduled for 4th quarter 2020. The DON will be responsible for ongoing compliance of disaster drills and documentation records. The disaster drills will be audited x2 for 3 months, then monthly x3 month and then quarterly or until 100% compliance is reached. DON/ ADON or designee will monitor to ensure compliance and results will be reviewed at the QA/ QAPI meetings.	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101	E 041		10/10/20

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and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.

482.15(e)(2), §483.73(e)(2), §485.625(e)(2)
Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.

482.15(e)(3), §483.73(e)(3), §485.625(e)(3)
Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.

*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):]
The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html.
If any changes in this edition of the Code are

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E 041	Continued From page 11 incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the emergency generator was tested and maintained in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections, 9.1.3 and NFPA 110 "Standard for Emergency and Standby Power Systems 6-4, 6-4.1, and 6-4.2.2. This had the potential to affect all 30 residents residing in the facility.	E 041	Weekly generator inspections were started on 8/24/20. Education and instruction was done with maintenance employee 8/24/20 to ensure generator was inspected weekly. This will continue to be done by EVS or designee. Jaime Burg EVS will be responsible for monitoring to prevent a reoccurrence of the deficiency.	

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E 041	Continued From page 12 Findings include: On 8/19/20, between 11:30 a.m. and 3:30 p.m. during a facility tour, a review of all available emergency generator maintenance documentation, and an interview with the environmental supervisor (ES) revealed that the facility lacked documentation for 52 of 52 weekly inspections of the emergency generator. ES verified maintenance records lacked documentation of weekly generator inspections.	E 041	The generator inspection log will be audited x2 for 3 months, then monthly x3 month and then quarterly or until 100% compliance is reached. DON/ ADON or designee will monitor to ensure compliance and results will be reviewed at the QA/ QAPI meetings.	
F 000	INITIAL COMMENTS On 8/17/20, through 8/20/20, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5374019C with no deficiencies written. The following complaints were found to be UNSUBSTANTIATED: H5374017C H5374018C H5374020C H5374021C H5374022C H5374023C The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are	F 000		

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F 000	Continued From page 13 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure protective sleeves were applied to arms and legs, and dressing changes were completed as ordered and directed in the plan of care care for 1 of 5 residents (R22) reviewed for skin conditions. Findings include: R22's Admission Record dated 8/20/20, indicated R22's diagnoses included Type 2 diabetes mellitus, and long term use of an anticoagulant (medication to prevent blood clots).	F 684	R22's treatments were updated so each area of skin care area was separate. Skin protectant sleeves were obtained and donned. All residents have the potential to be affected by this deficiency. Staff were educated on 9-18-20 that each wound requires a separate sign off box. All resident tx will be reviewed by correction date for accuracy and ensured each wound has a separate treatment.	10/10/20

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F 684	Continued From page 14 R22's admission Minimum Data Set (MDS) dated 7/21/20, identified R22 was cognitively intact, and had no skin concerns. R22's care plan dated 7/21/20, identified R22 had multiple skin tears, bruising over arms, legs, surgical wounds on right hip and leg, and bilateral venous stasis ulcers. R22's care plan directed to observe skin daily, protect skin with long sleeves, tubi-grips or other skin protecting layers, and treatments as ordered. R22's nursing assistant care guide sheet dated 8/20/20, directed to protect R22's skin with long sleeves, tubi-grips or other protecting layers. R22's Physician Orders signed 7/18/20, directed staff to apply geri-sleeves or tubi-grips to all extremities in the a.m. and to remove while in bed to protect R22's skin. Cleanse skin tears on arms with wound cleanser, pat dry with gauze, cover with Adaptic (dressing) followed by Telfa (dressing) and wrap to hold in place. Change every three days and as needed, when drainage is visible or wrap is no longer stay in place. The orders further directed if a new area on the arms tears or peels, cleanse area with wound cleanser, pat dry with clean gauze, and cover with appropriate Mepilex (dressing) until all dressing changes are due to be changed. R22's treatment administration record (TAR) for August 2020, directed to apply geri-sleeves or tubi-grip to all extremities in the a.m., ok to remove when in bed. R22's TAR further directed to change arm and leg dressings every three days, and as needed when dressing were viably soiled.	F 684	DON/ ADON or designee will audit 4 skin tx orders per month x3 months, then 2 residents per month x 3 then 1 monthly x 3 months or until 100% compliance.	

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F 684	Continued From page 15 On 8/17/20, at 7:04 p.m. R22 was observed having two square foam bandages one located on the right forearm, and the other on right upper arm both dated 8/15. On 8/19/20, at 1:10 p.m. R22 was observed sitting in his recliner, and was not wearing tubi-grips or protective coverings to his lower legs or arms. On 8/19/20, at 2:10 p.m. R22 was observed to have the same two foam bandages on his right arm dated 8/15. R22 had one foam dressing to his left upper arm, dated 8/17, and on on his right shin dated 8/17. R22 was not wearing his tubi-grips or protective coverings on his arms or legs. On 8/19/20, at 2:11 p.m. R22 was observed sitting in his recliner, and a pair of tubi-grips were observed on the bed siderail. R22 stated he was not wearing his arm sleeves because they haven't been able to find them. R22 stated yesterday staff put the tubi-grips that were meant for his legs on his arms, which did no good because they were too big. On 8/20/20, at 8:41 a.m. R22 was observed in his room watching TV, and was not wearing his arm sleeves or tubi-grips to lower legs. On 8/20/20, 12:03 p.m. licensed practical nurse (LPN)-B stated R22's arm dressings were changed Monday (8/17/20), and were to be changed every 3 days . LPN-B stated R22's arm dressings were signed off on the treatment administration record (TAR) they were changed on 8/17/20. LPN-B went into R22's room and	F 684		

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verified R22's right arm dressings were both dated 8/15/20, and on R22's left arm the dressing was dated 8/17/20. LPN-B sated R22's right arm dressings should have been changed on 8/17/20, according to the physician orders. LPN-B verified R22's did not have his arm and leg-tubi grips on.

On 8/20/20, 1:16 p.m. LPN-A stated R22 wore tubi-grips on his arms and legs to protect his skin. LPN-A stated if a resident refused treatments she would expect staff to report the refusal to the nurse, so the nurse could document the refusal. LPN-A was unaware R22 did not have his tubi-grips on his arms or legs, and further stated she was unaware R22 had been missing his arm tubi-grips.

On 8/20/20, 1:37 p.m. nursing assistant (NA)-C stated R22 was to suppose to wear tubi-grips to his legs and arms when out of bed. NA-C stated R22 was not wearing his tubi-grips because she could only find the ones for legs, and the ones for his arms had been missing for a couple of days. NA-C stated she reported R22's missing tubi-grips to the nurse, but was unable to recall what nurse she reported it to.

On 8/20/20, at 1:50 p.m. the director of nursing (DON) stated staff would be expected to follow physician orders for dressing changes and treatments. The DON stated if a residents tubi-grips were missing, she would expect staff to look for them in their rooms and laundry, and if unable to locate, notify the nurse to document in the residents medical record, and reorder a new pair. The DON stated if a resident's dressing change was due to be changed and five days later that the dressing had not been changed, she would expect the resident's wound to be

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 17 reassessed, and the medical provider be notified. A facility policy on following physician orders and care plans were requested and not provided.	F 684		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders and/or pharmacy instructions for 2 of 5 residents (R28, R18) observed for medication administration. This resulted in a facility medication administration error rate of 6.67% (percent). Findings include: R28's medical record was reviewed to reconcile the medications observed with the physician orders in which R28's consolidated orders report signed on 8/6/20, instructed staff to administer 20 mg (milligrams) of furosemide each morning. On 8/19/20, at 7:29 a.m. a trained medication aide (TMA)-A prepared medications for R28 where she removed a medication bubble pack containing furosemide (a medication to remove excess fluid from the body) 20 milligram tablets from the medication cart. The furosemide label directed to administer a 1/2 tablet (10 mg) orally	F 759	R28 was assessed on 8/20/20, orders were clarified and no adverse reactions have occurred. R18's 8.5 grams of Miralax order was updated on 8/22/20 to reflect appropriate dissolving 4 ounces of fluid per manufacturer guidelines & resident preference, no harm occurred due to missing directions. All residents are at risk to be affected by this tag. All residents' pharmacy labels will by compared with MAR for accuracy by 10/10/20 and updated prn. Staff will be educated on 9/18/20 to include amount of fluid to mix with miralax powder on all Miralax orders and procedure for updating pharmacy if label does not match the MAR. Then 3 residents weekly x1 month, then 1 resident weekly x1 month and then 1 resident quarterly or until 100% compliance is reached.	10/10/20

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F 759	Continued From page 18 every morning for a diagnosis of congestive heart failure (CHF) (congestive heart failure: heart disease that affects pumping action of the heart muscles). TMA-A placed one-half tablet of furosemide in a medication cup, and administered it to R28 with her additional morning medications. On 8/19/20, at 12:57 p.m. the director of nursing (DON) compared R28's current furosemide order to the furosemide packaging label. After, she stated staff should have administered 2 tablets (2 half tablets) of furosemide to R28. During interview on 8/20/20, at 12:47 p.m. TMA-A stated, "Usually their [residents'] cards [medication bubble packs] have the right dose and I took for granted that it [R28's medication and label] was correct." TMA-A expressed that she had been unsure how long she had given R28 only a half tab [10 mg] of the furosemide. R18's unsigned consolidated orders report printed 8/20/20, instructed staff to administer polyethylene glycol packet 8.5 g (grams) by mouth daily in the a.m. for constipation. The order failed to indicate the amount of fluids to be mixed with this medication, or any additional directions to follow manufacturers' instructions for administration. R18's Medication Administration Record (MAR), dated 8/1/20 to 8/31/20, directed staff to administer polyethylene glycol packet 8.5 g in the a.m. for constipation. Start date: 10/30/2019. The MAR failed to indicate the amount of fluids to be mixed with this medication, or any additional directions to follow manufacturers' instructions for administration.	F 759	DON/ ADON or designee will monitor to ensure compliance and results will be reviewed at the QA/ QAPI meetings.	

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F 759	Continued From page 19	F 759		

R18 was observed on 8/20/20, at 8:18 a.m. when licensed practical nurse (LPN)-A prepared medications to be administered to R18 at a mobile medication cart in the hallway outside of R18's room. LPN-A removed an opened container of polyethylene glycol powder (a laxative medication) and poured a measured amount into a clear, plastic cup, and mixed it with approximately 4 ounces (oz.) of water. LPN-A confirmed the glass contained 4 oz. of water. The polyethylene glycol powder medication label directed staff to mix this medication with "at least 8 oz. liquid" and drink daily for constipation. LPN-A handed the prepared medication to R18 upon entering his room in which he consumed the entire contents of the plastic cup. LPN-A offered R18 additional fluids, however, R18 declined. After, LPN-A failed to inform R18 of the printed pharmacy directions for this medication and/or of the risks and consequences of not following such directions. After exiting R18's room, LPN-A stated the amount of fluid that a resident received with this medication "depends on the person and how they like it." LPN-A explained that R18 "likes a smaller cup."

When interviewed on 8/20/20, at 2:11 p.m. the assistant director of nursing (ADON) stated staff would have been expected to administer 8 oz. of fluids with the polyethylene glycol powder per the pharmacy label. The ADON stated she had "always seen it written with 8 oz. [fluids]" The ADON further explained the facility had larger glasses for staff use, staff could have used water from R18's room, or staff could have split the medication between 2 smaller glasses. She expressed if R18 had not been administered the correct amount of water with this type of

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F 759	Continued From page 20 medication, the medication may not have broken down and dissolved for R18 "the way it should, effecting how it is utilized by the body. An undated facility standing orders policy directed for bowel constipation management staff should, "Encourage 2,000 mL [milliliters] daily fluid intake unless contraindicated." The policy failed to identify instructions on the amount of fluid to mix with polyethylene glycol powder and/or directions to follow manufacturers' instructions for use of this medication and/or any other medication administered to facility residents. A provided facility Medication Incidents/Errors policy, dated 4/3/15, identified a medication error as "a discrepancy between what was prescribed and what medications are actually administered to residents ..."	F 759		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medication was was administered in accordance with physician orders for 1 of 5 residents (R28) reviewed for medication administration. R28's quarterly Minimum Data Set (MDS) dated 8/3/20, indicated R28's diagnosis included heart failure, hypertension (high blood pressure), coronary artery disease (narrowing of major blood vessels), and renal insufficiency (poor functioning	F 760	R28 was assessed on 8/20/20, Lasix order was clarified, and no adverse reactions have occurred due to the dose error. All residents are at risk to be affected by this tag. All residents' pharmacy labels will by compared with MAR for accuracy by 10/10/20 and updated prn. Staff will be educated on 9/18/20 on watching ½ vs whole tab dosing and procedure for updating pharmacy if label	10/10/20

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F 760	Continued From page 21 of the kidneys). The MDS further identified R28 received diuretic medication (removes excess fluid from the body) seven days during the review period, and that she had intact cognition. R28's Medication Administration Record (MAR) dated 8/1/20 to 8/31/20, directed staff to administer furosemide (diuretic) 20 milligrams in the morning. On 8/19/20, at 7:29 a.m. trained medication aide (TMA)-A prepared medications for R28 in which she removed a medication bubble pack which contained furosemide 20 mg tablets (which were cut in half to equal 10 mg) from the medication cart. The furosemide label directed to administer a 1/2 tablet (10 mg) orally every morning for a diagnosis of CHF. TMA-A placed one-half tablet of furosemide in a medication cup, and administered it to R28 with her additional morning medications. R28's medical record was reviewed to reconcile the medications observed with the physician orders. R28's consolidated orders report signed on 8/6/20, instructed staff to administer 20 mg of furosemide each morning. On 8/19/20, at approximately 12:45 p.m. R28's furosemide medication bubble pack was observed with the director of nursing (DON). The DON confirmed R28's furosemide medication bubble pack failed to alert staff the package label differed from the current physician order. The bubble pack indicated it had been refilled on 8/18/20. The bubble pack contained 13 furosemide tablets which were cut in half. One dose of furosemide was removed.	F 760	does not match the MAR. Then 3 residents weekly x1 month, then 1 resident weekly x1 month and then 1 resident quarterly or until 100% compliance is reached. DON/ ADON or designee will monitor to ensure compliance and results will be reviewed at the QA/ QAPI meetings.	

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F 760	Continued From page 22	F 760		

On 8/19/20, at 12:57 p.m. the DON compared R28's current furosemide order to the furosemide packaging label. Immediately after, she stated staff should have administered 2 tablets (2 half tablets) of furosemide to R28 that morning.

When interviewed on 8/19/20, at 1:46 p.m. the pharmacist stated when the nursing home had requested a refill of R28's furosemide the pharmacy dispensed a 14 day supply of furosemide 20 mg 1/2 tablets (10 mg) based on the order they had received dated 5/28/19. She confirmed the furosemide order on file with the pharmacy was to dispense furosemide 20 mg tablets with the direction to give a 1/2 tablet (10 mg) in the morning. The pharmacist further explained that if the pharmacy had an order on file for R28 to have taken a total of 20 mg of furosemide each day, the pharmacy would have packaged the whole 20 mg tablet and not just half a tablet.

During interview on 8/20/20, at 12:47 p.m. TMA-A stated, "Usually their [residents'] cards [medication bubble packs] have the right dose and I took for granted that it was correct." TMA-A expressed that she had been unsure of how long she may have been giving R28 a half tab [10 mg] of the furosemide.

When interviewed on 8/20/20, at 2:11 p.m. the assistant director of nursing (ADON) stated Lasix was a high risk medication and that "it is a big thing" R28 did not receive her Lasix as ordered. The ADON explained that by R28 not having had received the correct ordered dose of the Lasix, R28 could have retained too much fluid; thus affecting her heart.

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F 760	Continued From page 23 The facility policy Medication Incidents/Errors dated 4/3/15, identified a medication error as A discrepancy between what was prescribed and what medications are actually administered to residents .	F 760		

Electronically delivered
September 9, 2020

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

Re: State Nursing Home Licensing Orders
Event ID: Q5B711

Dear Administrator:

The above facility was surveyed on August 17, 2020 through August 20, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Teresa Ament, Unit Supervisor
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00451	A. BUILDING: _____ B. WING _____	C 08/20/2020

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/17/20, through 8/20/20, surveyors of this Department's staff visited the above provider and the following correction orders are issued. In addition, complaint investigations were completed at the time of the licensing survey.	2 000		

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2 000	Continued From page 1 Complaint H5374019C was substantiated. The following complaints were not substantiated: H5374017C H5374018C H5374020C H5374021C H5374022C H5374023C Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be	2 000		

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2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure protective sleeves were applied to arms and legs, and dressing changes were completed as ordered and directed in the plan of care care for 1 of 5 residents (R22) reviewed for skin conditions.	2 830	Corrected	10/10/20

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2 830	Continued From page 3 Findings include: R22's Admission Record dated 8/20/20, indicated R22's diagnoses included Type 2 diabetes mellitus, and long term use of an anticoagulant (medication to prevent blood clots). R22's admission Minimum Data Set (MDS) dated 7/21/20, identified R22 was cognitively intact, and had no skin concerns. R22's care plan dated 7/21/20, identified R22 had multiple skin tears, bruising over arms, legs, surgical wounds on right hip and leg, and bilateral venous stasis ulcers. R22's care plan directed to observe skin daily, protect skin with long sleeves, tubi-grips or other skin protecting layers, and treatments as ordered. R22's nursing assistant care guide sheet dated 8/20/20, directed to protect R22's skin with long sleeves, tubi-grips or other protecting layers. R22's Physician Orders signed 7/18/20, directed staff to apply geri-sleeves or tubi-grips to all extremities in the a.m. and to remove while in bed to protect R22's skin. Cleanse skin tears on arms with wound cleanser, pat dry with gauze, cover with Adaptic (dressing) followed by Telfa (dressing) and wrap to hold in place. Change every three days and as needed, when drainage is visible or wrap is no longer stay in place. The orders further directed if a new area on the arms tears or peels, cleanse area with wound cleanser, pat dry with clean gauze, and cover with appropriate Mepilex (dressing) until all dressing changes are due to be changed. R22's treatment administration record (TAR) for	2 830		

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2 830	Continued From page 4 August 2020, directed to apply geri-sleeves or tubi-grip to all extremities in the a.m., ok to remove when in bed. R22's TAR further directed to change arm and leg dressings every three days, and as needed when dressing were viably soiled. On 8/17/20, at 7:04 p.m. R22 was observed having two square foam bandages one located on the right forearm, and the other on right upper arm both dated 8/15. On 8/19/20, at 1:10 p.m. R22 was observed sitting in his recliner, and was not wearing tubi-grips or protective coverings to his lower legs or arms. On 8/19/20, at 2:10 p.m. R22 was observed to have the same two foam bandages on his right arm dated 8/15. R22 had one foam dressing to his left upper arm, dated 8/17, and on on his right shin dated 8/17. R22 was not wearing his tubi-grips or protective coverings on his arms or legs. On 8/19/20, at 2:11 p.m. R22 was observed sitting in his recliner, and a pair of tubi-grips were observed on the bed siderail. R22 stated he was not wearing his arm sleeves because they haven't been able to find them. R22 stated yesterday staff put the tubi-grips that were meant for his legs on his arms, which did no good because they were too big. On 8/20/20, at 8:41 a.m. R22 was observed in his room watching TV, and was not wearing his arm sleeves or tubi-grips to lower legs. On 8/20/20, 12:03 p.m. licensed practical nurse (LPN)-B stated R22's arm dressings were	2 830		

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	00451	A. BUILDING: _____ B. WING _____	C 08/20/2020

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2 830	Continued From page 5	2 830		

changed Monday (8/17/20), and were to be changed every 3 days . LPN-B stated R22's arm dressings were signed off on the treatment administration record (TAR) they were changed on 8/17/20. LPN-B went into R22's room and verified R22's right arm dressings were both dated 8/15/20, and on R22's left arm the dressing was dated 8/17/20. LPN-B sated R22's right arm dressings should have been changed on 8/17/20, according to the physician orders. LPN-B verified R22's did not have his arm and leg-tubi grips on.

On 8/20/20, 1:16 p.m. LPN-A stated R22 wore tubi-grips on his arms and legs to protect his skin. LPN-A stated if a resident refused treatments she would expect staff to report the refusal to the nurse, so the nurse could document the refusal. LPN-A was unaware R22 did not have his tubi-grips on his arms or legs, and further stated she was unaware R22 had been missing his arm tubi-grips.

On 8/20/20, 1:37 p.m. nursing assistant (NA)-C stated R22 was to suppose to wear tubi-grips to his legs and arms when out of bed. NA-C stated R22 was not wearing his tubi-grips because she could only find the ones for legs, and the ones for his arms had been missing for a couple of days. NA-C stated she reported R22's missing tubi-grips to the nurse, but was unable to recall what nurse she reported it to.

On 8/20/20, at 1:50 p.m. the director of nursing (DON) stated staff would be expected to follow physician orders for dressing changes and treatments. The DON stated if a residents tubi-grips were missing, she would expect staff to look for them in their rooms and laundry, and if unable to locate, notify the nurse to document in the residents medical record, and reorder a new

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2 830	Continued From page 6 pair. The DON stated if a resident's dressing change was due to be changed and five days later that the dressing had not been changed, she would expect the resident's wound to be reassessed, and the medical provider be notified. A facility policy on following physician orders and care plans were requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop or revise policies/procedures related to providing treatments according to the care plan and physician orders. The DON or designee, could train staff in implementation of the policies, care plans and physician orders. The DON or designee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of	21426		10/10/20

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21426	Continued From page 7 Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure two-step tuberculin skin tests (TST) were completed for 2 of 4 employees (DA-A, NA-A). Findings include: Dietary Aide (DA)-A's Mantoux PPD Skin Testing form revealed hire date of 6/15/20. DA-A received the initial TST on 6/12/20, and the second TST on 6/22/20. The second TST was read on 6/24/20, however, the millimeters of induration was not documented on the form. Nursing assistant (NA)-A's Nursing Assistant Student Tuberculin (Mantoux) Record indicated NA-A received the initial TST on 2/14/20, and was read on 2/17/20. The form lacked indication NA-A received the second-step TST, and had not provided evidence of a negative TST dated within 90 days prior to date of hire. The facility's Tuberculosis Exposure Control Plan review date 8/1/19, indicated TST screening for tuberculosis was required upon hire for all employees as required by statute or regulation.	21426	Corrected	

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21426	Continued From page 8 Suggested Method for Correction: The director of nursing (DON) or designee could review the facility system in place to ensure newly admitted residents and newly hired staff receive screening of TB symptoms and the TST as required by state rule, and appropriate reading and documentation of the TST results. The director of nursing (DON) or designee could educate staff on the system in place. The director of nursing (DON) or designee could monitor and review the delivery of the TST. Time Period for Correction: Twenty one (21) days	21426		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single	21545		10/10/20

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21545	Continued From page 9 medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were administered in accordance with physician orders and/or pharmacy instructions for 2 of 5 residents (R28, R18) observed for medication administration. This resulted in a facility medication administration error rate of 6.67% (percent). Findings include: R28's medical record was reviewed to reconcile the medications observed with the physician orders in which R28's consolidated orders report signed on 8/6/20, instructed staff to administer 20	21545	Corrected	

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21545	Continued From page 10 mg (milligrams) of furosemide each morning. On 8/19/20, at 7:29 a.m. a trained medication aide (TMA)-A prepared medications for R28 where she removed a medication bubble pack containing furosemide (a medication to remove excess fluid from the body) 20 milligram tablets from the medication cart. The furosemide label directed to administer a 1/2 tablet (10 mg) orally every morning for a diagnosis of congestive heart failure (CHF) (congestive heart failure: heart disease that affects pumping action of the heart muscles). TMA-A placed one-half tablet of furosemide in a medication cup, and administered it to R28 with her additional morning medications. On 8/19/20, at 12:57 p.m. the director of nursing (DON) compared R28's current furosemide order to the furosemide packaging label. After, she stated staff should have administered 2 tablets (2 half tablets) of furosemide to R28. During interview on 8/20/20, at 12:47 p.m. TMA-A stated, "Usually their [residents'] cards [medication bubble packs] have the right dose and I took for granted that it [R28's medication and label] was correct." TMA-A expressed that she had been unsure how long she had given R28 only a half tab [10 mg] of the furosemide. R18's unsigned consolidated orders report printed 8/20/20, instructed staff to administer polyethylene glycol packet 8.5 g (grams) by mouth daily in the a.m. for constipation. The order failed to indicate the amount of fluids to be mixed with this medication, or any additional directions to follow manufacturers' instructions for administration.	21545		

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21545	Continued From page 11 R18's Medication Administration Record (MAR), dated 8/1/20 to 8/31/20, directed staff to administer polyethylene glycol packet 8.5 g in the a.m. for constipation. Start date: 10/30/2019. The MAR failed to indicate the amount of fluids to be mixed with this medication, or any additional directions to follow manufacturers' instructions for administration. R18 was observed on 8/20/20, at 8:18 a.m. when licensed practical nurse (LPN)-A prepared medications to be administered to R18 at a mobile medication cart in the hallway outside of R18's room. LPN-A removed an opened container of polyethylene glycol powder (a laxative medication) and poured a measured amount into a clear, plastic cup, and mixed it with approximately 4 ounces (oz.) of water. LPN-A confirmed the glass contained 4 oz. of water. The polyethylene glycol powder medication label directed staff to mix this medication with "at least 8 oz. liquid" and drink daily for constipation. LPN-A handed the prepared medication to R18 upon entering his room in which he consumed the entire contents of the plastic cup. LPN-A offered R18 additional fluids, however, R18 declined. After, LPN-A failed to inform R18 of the printed pharmacy directions for this medication and/or of the risks and consequences of not following such directions. After exiting R18's room, LPN-A stated the amount of fluid that a resident received with this medication "depends on the person and how they like it." LPN-A explained that R18 "likes a smaller cup." When interviewed on 8/20/20, at 2:11 p.m. the assistant director of nursing (ADON) stated staff would have been expected to administer 8 oz. of fluids with the polyethylene glycol powder per the pharmacy label. The ADON stated she had	21545		

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21545	Continued From page 12 "always seen it written with 8 oz. [fluids]" The ADON further explained the facility had larger glasses for staff use, staff could have used water from R18's room, or staff could have split the medication between 2 smaller glasses. She expressed if R18 had not been administered the correct amount of water with this type of medication, the medication may not have broken down and dissolved for R18 "the way it should, effecting how it is utilized by the body. An undated facility standing orders policy directed for bowel constipation management staff should, "Encourage 2,000 mL [milliliters] daily fluid intake unless contraindicated." The policy failed to identify instructions on the amount of fluid to mix with polyethylene glycol powder and/or directions to follow manufacturers' instructions for use of this medication and/or any other medication administered to facility residents. A provided facility Medication Incidents/Errors policy, dated 4/3/15, identified a medication error as "a discrepancy between what was prescribed and what medications are actually administered to residents ..." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop or revise policies/procedures related to administration of medications and prevention of medication errors. The DON or designee, could educate staff in the policies and medication administration. The DON or designee, could monitor and audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		

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	245374	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/19/2020**

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K 000	INITIAL COMMENTS FIRE SAFETY Building 01 - Main Building: 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 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Lakeside Medical Center C & NC 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000		

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

Electronically Signed | 09/16/2020

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K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lakeside Medical Center C & NC is a 1-story building with a full basement. The original building was constructed in 1966 with an addition constructed in 1971. The 1966 building is of type II(111) construction and the 1971 building is type II(111) construction. Therefore, the nursing home was inspected as one building. The facility has a small hospital and clinic, attached, and they are properly separated from the nursing home. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for	K 000		

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K 000	Continued From page 2 automatic fire department notification. The facility has a licensed capacity of 46 beds and had a census of 30 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a) are NOT met.	K 000		
K 341 SS=D	Fire Alarm System - Installation CFR(s): NFPA 101 Fire Alarm System - Installation A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. In areas not continuously occupied, detection is installed at each fire alarm control unit. In new occupancy, detection is also installed at notification appliance circuit power extenders, and supervising station transmitting equipment. Fire alarm system wiring or other transmission paths are monitored for integrity. 18.3.4.1, 19.3.4.1, 9.6, 9.6.1.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2012 NFPA 101, "The Life Safety Code" Sections 19.3.4.1 and 9.6, as well as 2010 NFPA 72, "National Fire Alarm and Signaling Code"	K 341	Call was placed to facilities Fire Alarm Company; ESC Systems 9/1/20 to discuss the smoke detector bracket. ESC Systems sent a replacement bracket to facility. New bracket was placed and smoke detector was reinstalled properly	9/16/20

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K 341	Continued From page 3 sections 29.8.3.4. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affect 15 of 46 residents located in one smoke compartment. Findings include: On facility tour between 11:30 a.m. and 3:30 p.m. on 08/19/2020, observation revealed, that the smoke detector located in the 1st dining room was hanging by the wires and not secure into its mounting base. This deficient condition was confirmed by a Maintenance Supervisor.	K 341	on 9/14/20. Visual check of initiating devices will be done every 6 months starting 10/1/20 to ensure that all components are functioning properly. This will be done by EVS or designee. Jaime Burg will be responsible for monitoring to prevent a reoccurrence of the deficiency.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on review of reports, records and staff	K 712	Fire Drills will be completed every month	9/16/20

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K 712	Continued From page 4 interview, it was determined that the facility failed to conduct 6 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12 months. This deficient practice could affect 46 of 46 residents. Findings include: On facility tour between 11:30 a.m. and 3:30 p.m. on 08/19/2020, during the review of all available fire drill documentation and interview with the Maintenance Supervisor the following deficient conditions were found: 1. The facility failed to vary the times of the fire drills by conducting 3 of 4 fire drills during the 4 p.m. hour. 2. The facility failed to verify DACT alarm transmissions to the monitoring company for 3 of 12 fire drills. All 3 identified instances had occurred during the overnight shift fire drills. This deficient condition was confirmed by a Maintenance Supervisor.	K 712	by Environmental Services Supervisor or designee. This will amount to each shift having 4 Fire Drills per year. This will ensure that staff is familiar with procedures and are aware that drills are a part of established routine at the facility. With each monthly drill Environmental Supervisor will review previous drills to ensure that drills are being done at different intervals. Environmental Supervisor will also ensure that Fire Drill Report is filled out correctly when placed in Fire Book. Jaime Burg performed correction. Jaime Burg EVS will be responsible for monitoring to prevent a reoccurrence of the deficiency.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not	K 914		9/16/20

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	245374	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/19/2020**

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K 914	Continued From page 5 listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This deficient practice could affect the safety of 46 of 46 residents. Findings include: On facility tour between 11:30 a.m. and 3:30 p.m. on 08/19/2020, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the current completion of the annual electrical outlet inspection and testing for the electrical outlets located in the patient/resident rooms located throughout the facility. The last annual electrical outlet inspection had been completed in June of 2019 and is out of date. This deficient condition was confirmed by a	K 914	Outlet inspection and testing for facility was conducted and finished on 8/26/20. Outlet inspection and testing was added to preventative maintenance worksheets to ensure that it is performed yearly. Education with maintenance employee to cover the importance of inspection and testing done by Jaime Burg EVS 8/26/20. Jaime Burg EVS will be responsible for monitoring to prevent a reoccurrence of the deficiency.	

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K 914	Continued From page 6 Maintenance Supervisor.	K 914		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System 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)	K 918		9/16/20

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K 918	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test and maintain the emergency generator in accordance with the requirements of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections, 9.1.3 and NFPA 110 "Standard for Emergency and Standby Power Systems 6-4, 6-4.1, and 6-4.2.2. This deficient practice could affect the safety of 46 of 46 residents. Findings include: On facility tour between 11:30 a.m. and 3:30 p.m. on 08/19/2020, during the review of all available emergency generator maintenance documentation and an interview with the Maintenance Supervisor it was revealed that the facility could not provide documentation for 52 of 52 weekly inspections of the emergency generator. This deficient condition was confirmed by a Maintenance Supervisor.	K 918	Weekly generator inspections were started on 8/24/20. Education and instruction was done with maintenance employee 8/24/20 to ensure generator was inspected weekly. This will continue to be done by EVS or designee. Jaime Burg EVS will be responsible for monitoring to prevent a reoccurrence of the deficiency.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal	K 920		9/16/20

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K 920	Continued From page 8 electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and interview with the staff the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.1.2, the NFPA 70 "National Electrical Code" 2011 edition and the NFPA 99 " Healthcare Facilities Code" 2012. This deficient practice could affect 10 of 46 residents. Findings include: On facility tour between 11:30 a.m. and 3:30 p.m. on 08/19/2020, observations revealed the following deficient conditions: 1. In the nurses report room there were two power strips daisy chained together by the copier located in the room. 2. In the nurses report room there were two	K 920	All effected power strips and outlets were addressed and fixed 8/19/20. Outlet cover was replaced 8/20/20. Jaime Burg performed correction. A visual check of areas in the facility that utilize power strips was done 8/20/20 to ensure cords were being used properly. All staff will be educated on proper use of power strips, and how to report maintenance needs in regards to missing outlet cover 9/18/20. Jaime Burg EVS will be responsible for monitoring to prevent a reoccurrence of the deficiency.	

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K 920	Continued From page 9 power strips daisy chained together by the refrigerator located in the room. 3. In the nurses report room the refrigerator was plugged into a power strip that was also being used to power multiple electric patient/resident left battery chargers creating an overdraw of the rated amperes capacity for the prowler strips. This deficient condition was confirmed by a Maintenance Supervisor.	K 920		