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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QL64

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00773

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245533**

2.STATE VENDOR OR MEDICAID NO.
(L2) **314182000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKESIDE HEALTH CARE CENTER**
(L4) **439 WILLIAM AVENUE EAST, PO BOX 383**
(L5) **DASSEL, MN** (L6) **55325**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/07/2018** (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 **54** (L18)
13.Total Certified Beds **54** (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
	54			
(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:
LoAnn DeGagne, HFE - NE II — 06/14/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 06/14/2018 (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
01/24/1989
(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
05/24/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245533 June 14, 2018

Ms. Brianne Wolters, Administrator
Lakeside Health Care Center
439 William Avenue East, PO Box 383
Dassel, MN 55325

Dear Ms. Wolters:

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 June 1, 2018 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

Electronically delivered
June 14, 2018

Ms. Brianne Wolters, Administrator
Lakeside Health Care Center
439 William Avenue East, PO Box 383
Dassel, MN 55325

RE: Project Number S5533027

Dear Ms. Wolters:

On May 10, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective May 15, 2018. (42 CFR 488.422)

- Discrentionary denial of payment for new Medicare and Medicaid admissions effective July 15, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on April 26, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 7, 2018, the Minnesota Department of Health and Public Safety completed a Post Certficiation Review (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 26, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 1, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 26, 2018, as of June 1, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 1, 2018.

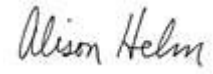
In our letter of May 10, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 15, 2018, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 1, 2018 the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 14, 2018

Ms. Brianne Wolters, Administrator
Lakeside Health Care Center
439 William Avenue East, Po Box 383
Dassel, MN 55325

Re: Reinspection Results - Project Number S5533027

Dear Ms. Wolters:

On June 7, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on June 7, 2018, with orders received by you on May 11, 2018. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@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: QL64

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00773

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245533**

2.STATE VENDOR OR MEDICAID NO.
(L2) **314182000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKESIDE HEALTH CARE CENTER**
(L4) **439 WILLIAM AVENUE EAST, PO BOX 383**
(L5) **DASSEL, MN** (L6) **55325**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/26/2018** (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 **54** (L18)
13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X 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: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(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:
Carlene Lange, HFE - NE II 05/22/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 05/23/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/24/1989
(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

Electronically delivered

May 10, 2018

Ms. Brianne Wolters, Administrator
Lakeside Health Care Center
439 William Avenue East, PO Box 383
Dassel, MN 55325

RE: Project Number S5533027

Dear Ms. Wolters:

On April 26, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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

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

Appeal Rights – the facility rights to appeal imposed remedies; and

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **OR**
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; **OR**
- Any G level deficiency is identified on the current survey in 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 CFR 483.24, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective May 15, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions effective July 15, 2018. (42 CFR § 488.417(a))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 15, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 15, 2018.

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

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Lakeside Health Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 15, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions

are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 July 15, 2018, the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 26, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

Washington, D.C. 20201
(202) 565-9462

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

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@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
	245533	A. BUILDING _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE HEALTH CARE CENTER	439 WILLIAM AVENUE EAST, PO BOX 383 DASSEL, MN 55325

(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 for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/23/18 through 4/26/18 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 4/23/18 through 4/26/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which	F 580		6/1/18

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

Electronically Signed | 05/16/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245533	A. BUILDING _____ B. WING _____	04/26/2018

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LAKESIDE HEALTH CARE CENTER	439 WILLIAM AVENUE EAST, PO BOX 383 DASSEL, MN 55325

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F 580	Continued From page 1 results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct	F 580		

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F 580	Continued From page 2 part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to notify the physician timely when an antihypertensive medication was inconsistently held or inappropriately not held when blood pressure (BP) was outside of the ordered parameters, and when the resident routinely refused to take an ordered diuretic, for 1 of 5 residents (R8) reviewed for unnecessary medications. Findings include: R8's Minimum Data Set (MDS), dated 2/9/18, identified R8 was cognitively intact with active diagnoses of heart failure, diabetes mellitus, hypertension (high blood pressure), chronic obstructive pulmonary disease, and shortness of breath. R8's current physician orders, printed 4/26/18, identified R27 took several medications, including but not limited to, the following medications: -furosemide (used to treat too much fluid) 40 milligrams (mg) once daily in the morning, and 20 mg once daily at noon, for heart failure. -metoprolol succinate extended release (antihypertensive medication) 12.5 mg once daily in the morning for heart failure, with special instructions, "administer with food. Hold metoprolol if BP [blood pressure] below 120/65. goal for BP should be 130 systolic [maximum pressure during one heart beat] and diastolic [minimum pressure in between two heart beats] <90."	F 580	Immediate Plan of Correction :Physician was updated via fax on 4/26/18 of R8□s refusal of medication (lasix) and of medication not being held when BP falling outside of parameters. MD responded on 4/27/18 and decreased lasix dosage and changed parameters for BP to address both systolic and diastolic parameters for holding metoprolol. Identification of Other Residents: An audit was done of all residents on 5-1-18 to identify medications with parameters to ensure they are being followed by reviewing the medication administration compliance report. Measures put in Place: Licensed nursing staff were educated on following parameters for med administration and informing Resident Care Coordinator about resident refusals at nurses meeting on 5-10-18. The Medication Administration Policy was reviewed and nurses were educated on updating physician if a pattern of refusals is noted. Monitoring Mechanisms: The medication compliance report will be reviewed weekly X 4 weeks and then monthly X 2 months by RN/DON to audit parameters. Results of audits will be reviewed by the QAPI committee.	

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F 580	Continued From page 3 R8's Medication Administration Record (MAR), from 4/1/18 to 4/26/18, identified: -On 4/1/18, R8's BP was 104/62. Although R8's BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given. -On 4/2/18, R8's BP was 112/64. Although R8's BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given. -On 4/7/18, R8's BP was 104/58. Although R8's BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given. -On 4/15/18, R8's BP was 118/64. Although R8's BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given. -On 4/16/18, R8's BP was 110/50. Although R8's BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given. -On 4/18/18, R8's BP was 113/72. Although R8's BP was above the parameters ordered for diastolic blood pressure, R8's MAR had initials in the box, indicating the metoprolol was held. -On 4/19/18, R8's BP was 105/68. Although R8's BP was below the parameters ordered for systolic blood pressure, R8's MAR had initials in the box, indicating the metoprolol was given. On this same day, furosemide was not given at noon due to R8's refusal. -On 4/20/18, R8's BP was 112/68. Although R8's BP was above the parameters ordered for diastolic blood pressure, R8's MAR had initials in the box, indicating the metoprolol was held. -On 4/21/18, at noon, R8 refused his furosemide. -On 4/22/18, at noon, R8 refused his furosemide.	F 580	Person Responsible: Director of Nursing Date of Completion: June 1, 2018	

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F 580	Continued From page 4	F 580		

-On 4/23/18, at noon, R8 refused his furosemide.
-On 4/24/18, at noon, R8 refused his furosemide.
-On 4/26/18, R8's BP was 115/74. Although R8's BP was above the parameters ordered for diastolic blood pressure, R8's MAR had initials in the box, indicating the metoprolol was held. On this same day, furosemide was not given at noon due to R8's refusal.

R8's record identified he had, on several occasions, received metoprolol succinate outside of the ordered parameters, or it had been held when it should have been given. In addition, R8 had refused his noon dose of furosemide for 6 of the last 8 days, from 4/19/18 through 4/26/19.

Review of R8's progress notes, dated 4/19/18, included, "BEHAVIOR: Resident refused Lasix [furosemide] today and stated, "I would rather die of heart failure than piss the bed." States he had been incontinent and wet his pants X 2 and wasn't happy about it. Continue to monitor."

During an observation and interview on 4/26/18, at 10:17 a.m. R8 was seated in a chair in his room. R8 stated he used a wheelchair or a four-wheeled walker for locomotion, and although he had a history of falling, denied feeling dizzy when ambulating or transferring. R8 had no obvious edema. R8 stated he had been telling the staff that he doesn't want to take his furosemide in the afternoons because he's "tired of peeing myself." R8 indicated staff had talked to him about why he should be taking the furosemide but stated, "I don't like that stuff."

During an interview on 4/26/18, at 10:49 a.m. registered nurse (RN)-A stated she was not aware that R8's metoprolol had been held several

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F 580	Continued From page 5	F 580		

times in the month of 4/18 due to BP being low, either systolic or diastolic, per ordered parameters, and on five occasions, was given metoprolol even though the systolic and diastolic BP were both lower than the ordered parameters and should have been held. RN-A stated she did not have time to check on each resident's medications every day and was not made aware of this. RN-A stated R8's physician had not been notified. RN-A indicated she had learned today in report that R8 had been refusing his furosemide. RN-A stated R8's physician had not been notified about that either.

In a follow up interview on 4/26/18, at 11:21 a.m. RN-A stated she was unclear what the ordered parameters meant, if staff were to hold the metoprolol if the BP was less than 120 systolic, or less than less than 65, or both systolic and diastolic needed to be less than 120/65 to hold it. RN-A stated the parameter order was unclear and verified that staff were inconsistently interpreting whether or not the metoprolol should be given, therefore, there was a potential for error. RN-A stated, "That's all on me. I should have notified the physician." RN-A stated she would be notifying R8's physician and would be clarifying the parameters for R8's BP and when the metoprolol should be held. Also, RN-A stated she would be notifying R8's physician that he had been refusing his furosemide.

During an interview on 4/26/18, at 3:13 p.m. director of nursing (DON) stated if refusals of medication were happening more than a couple of times, or if medication was being held, the RN/resident care coordinator should be notified and an update to the physician would be appropriate if there was no resolution.

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F 580	Continued From page 6 On 4/30/18, at 3:21 p.m. R8's physician's nurse returned phone call. She stated the physician is typically notified after 2-3 days of a resident refusing a medication, or a medication has been held due to being outside the ordered parameters, and the physician would have expected the staff to call if they needed clarification for the BP parameter order. Review of the facility's policy, Pharmaceutical (Medication) Administration Policy, revised 11/17, included, "When residents refuse medications this will be documented in the EMAR [electronic medical administration record] as Not Administered with an explanation of why it was not given. If a resident routinely refuses medication(s) the provider will be notified." Review of the facility's policy, Physician and Resident Representative notification, revised 11/16, included, "Primary Physicians, Residents, and the Resident representative, consistent with their authority, will be updated with all resident condition changes as soon as possible."	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC	F 585		6/1/18

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F 585	Continued From page 7 facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their	F 585		

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conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and
(vii) Maintaining evidence demonstrating the

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F 585	Continued From page 9 result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure prompt efforts were made to resolve ongoing grievances regarding uncomfortable room temperatures for 2 of 2 residents (R31, R194) reviewed, who complained their shared room was too warm. Findings include: R31's admission Minimum Data Set (MDS), dated 4/3/18, identified R31 had moderate cognitive impairment, and had diagnoses including chronic obstructive pulmonary disease, pneumonia, and anxiety. R31's care plan, dated 4/13/18, included R31 was alert and oriented, and was capable of expressing needs/preferences/wishes. Also included, R31 used oxygen, had trouble falling asleep at night, was feeling tired and more restless than usual. R194's resident face sheet, dated 4/19/18, identified diagnoses including chronic kidney disease, hypertension, and muscle weakness. R194's care plan, dated 4/23/18, identified R194 was alert and oriented, and capable of expressing needs/preferences/wishes. During an observation of medication administration with licensed practical nurse (LPN)-B on 4/25/18, at 8:15 a.m. R31 and R194 were in the room they shared, and complained their room was very warm. R31 stated the room	F 585	F285 Immediate Plan of Correction: . On 04/25/2018 Environmental Services Director replaced the thermostat in R 194's room. On 04/26/2018, resident R194 stated that her room was uncomfortable again. Maintenance employee went into resident room and replaced the valve control that was stuck. R194 has had no further concerns related to room temperature. Identification of other residents Facility staff have checked with all other residents to determine if there were any other concerns/grievances that had not been addressed. Any identified were promptly resolved. Measures put in place Facility staff were re-educated on the grievance process. Monitoring mechanisms Audits will be completed of 10% of residents per week X 1 month and then monthly X 2 months by checking with the residents to see if any concerns/grievances have been resolved. Results of audits will be brought to QAPI committee for review. Person responsible: Administrator Date of completion: 6/1/18	

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is "expletive hot" and pointed to the thermostat on the wall. R31 stated she had told "who ever would listen" since her admission on 3/21/18 that the temperature in the room was uncomfortably warm, and the staff had turned down the thermostat. The thermostat was observed with recorded temperature of 81 degrees Fahrenheit, and R194 reported, although the thermostat had been "shut off" earlier in the day, the room remained "Unbearably hot." R194 stated they had been "telling everyone we can," and indicated she had talked to her occupational therapist on 4/22/18, whom said she would "tell someone." R31 complained that the room was so uncomfortably warm, she couldn't sleep at night and could hardly breathe at times. The baseboard heat on the window side of the room was warm to touch and warm air was felt blowing out of the vents. LPN-B stated maintenance staff performed daily checks on temperatures in the residents' rooms and stated, "Yes, maintenance is well aware" that R31 and R194's room was too warm. LPN-B made no attempt to contact maintenance staff about R31 and R194's complaints of the uncomfortable temperature in their room, and continued to pass medications.

During an interview on 4/25/18, at 8:22 a.m. nursing assistant (NA)-D verified R31 and R194 had verbalized several times that their room was too warm, and stated she had reported it verbally to the environmental supervisor (ES) "on the go," and had put in a request on the tablet at the nurse's station, "a couple weeks ago," to have the temperature issue looked at. NA-D stated she had also put a fan in the room.

During an interview on 4/25/18, at 8:28 a.m. ES stated each resident room had an adjustable

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thermostat and the goal for minimum room temperature was 72 degrees. ES stated the warmth of the room was adjusted based on the resident's wishes. ES stated he was not aware of any complaints of rooms being too warm, especially on the west wing where R31 and R194 resided. Upon entering the room, ES stated, "My goodness, it is really hot in here." R31 stated, "I know, I live here." ES stated he would address the issue and stated, "I appreciate being told about this, I didn't know."

During a follow up interview on 4/25/18, at 8:49 a.m. ES stated, "We tell nurses and nursing assistants that if something is up, to come to someone and let them know." ES stated he had not been told and had not gotten anything about the heat in R31 and R194's room and stated staff were supposed to put a request into the "maintenancecare.com" tablet at the nurse's station, which was transmitted directly to his phone. ES reviewed the maintenance requests for the past month, and none were regarding the uncomfortable temperature in R31 and R194's room. ES stated, "Those are pretty easy fixes. They can stick on or stick off. We just need to be told about it." ES stated he had taken care of the issue in R31 and R194's room in "five minutes," and would be keeping any eye on it to make sure it was taken care of.

When interviewed on 4/25/18, at 8:59 a.m. R194 stated, "The temperature feels so much better." R31 stated, "I can't believe how much better it is, and he fixed it so quickly."

When interviewed on 4/26/18, at 3:07 p.m. the administrator indicated a grievance form was available for residents to file a grievance, but this

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F 585	Continued From page 12 issue should have been put into the maintenancecare.com system when R31 and R194 complained to staff of their discomfort in their room. The administrator stated, "This was never brought up," and indicated the process was not followed if floor staff were aware of the issue. The administrator stated, "They [staff] should have told someone." Review of the facility's policy, "Grievances: Registration and Disposition," revised 4/17, included, "Grievances can be filed orally or in writing and can be filed anonymously." Also included, "The staff person receiving the concern will initiate the Grievance form (106). Staff will assist residents to complete this form as needed." Further, "All grievances will be responded to within 7 days." Review of the facility's policy, "Facility Environment/Preventative Maintenance," revised 11/16, included, "Note: All employees will be encouraged and trained to report all needed repairs or unsanitary conditions immediately."	F 585		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow standards of practice related to medication administration for 1 of 1 residents (R38) observed to receive	F 658	Immediate plan of correction-- 1:1 coaching/education of nurse was done; spoke with R38□s daughter to review policy regarding medication administration	6/1/18

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F 658	Continued From page 13 medications during the evening meal, when medications were left with the family member to administer that were to administered by a licensed nurse. Findings include: R38's resident face sheet, dated 1/10/17, identified diagnoses including dementia without behavioral disturbance, legal blindness, and generalized muscle weakness. R38's quarterly Minimum Data Set (MDS), dated 4/12/18, identified R38 had severe cognitive impairment and required extensive assistance for all activities of daily living, including eating. R38's care plan, dated 4/10/18, included R38 had impaired cognition with diagnosis of dementia, was hard of hearing, and was legally blind. Further included, R38 was not able to make her needs/wants known consistently and had severe cognitive impairment. During a family interview on 4/23/18, at 6:21 p.m. in the dining room, R38's family member (FM)-A was assisting R38 to eat and requested to complete the interview while R38 continued to eat. Licensed practical nurse (LPN)-C walked into the dining room, carrying a medication cup that contained applesauce with a powdered white substance mixed in. FM-A stated, "She's not quite done yet," and directed LPN-C to "just leave it," and stated she would make sure R38 took the medication. FM-A stated, "It's just a blood pressure pill and one for her heart." LPN-C set the cup on the table in front of R38, and left the dining room. FM-A stated, "They do that in the mornings too. She's a slow eater. I just tell them	F 658	that the licensed nurse should administer medications. Identification of other residents□Isolated incident, no other residents involved. Measures put in place□education of nursing staff was completed at nurses meeting on 5-10-18. All nurses were assigned review of Medication Pass Protocol course in Relias, re-education of staff member involved was completed. Monitoring mechanisms Random medication pass audits will be completed with licensed staff X 2 months to ensure staff are following proper medication pass procedure. Results of audits will be reviewed by the QAPI committee Person responsible: Director of Nursing Date of completion: 6-1-18	

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to leave it and I'll get it down her." FM-A indicated she always gave R38 her medications before she was admitted to the facility. At 6:47 p.m. the medication cup remained on the table while R38 continued to eat with assistance from FM-A. At 6:57 p.m. FM-A spooned the contents of the medication cup into R38's mouth and wheeled her out of the dining room.

When interviewed on 4/23/18, at 7:28 p.m. LPN-C indicated if residents were alert and capable of taking their own medications, he would leave them for them to take, however, LPN-C stated someone with dementia or a stroke wasn't able to do that, so "we would wait with them until they swallow the medication." LPN-C stated, "For example, [R38], [FM-A] wants us to leave it on the table until she is done. If the family wants to give, we can leave it." When asked what the facility policy was regarding leaving medications for the resident to take or for the family to administer, LPN-C stated, "If the family wants to give the medication, we leave it, otherwise we don't have a policy to leave the medications. I had [FM-A's] permission to leave it." LPN-C verified the medications he left for FM-A to administer was carvedilol (used to treat congestive heart failure) and isosorbide dinitrate (used to treat heart failure and chest pain). LPN-C stated, "I always go there and check that they are taken. Tonight, I didn't, because [surveyor] were there."

Review of R38's Physician Order Report, copied 4/26/18, included carvedilol 3.125 milligrams (mg) twice daily with food, and isosorbide dinitrate 20 mg twice daily.

R38's Self Administration of Medications assessment, dated 1/11/17, identified R38 was

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F 658	Continued From page 15 "unable to understand the concept of self-administration of medications." When interviewed on 4/24/18, at 9:27 a.m. director of nursing (DON) stated she was aware that LPN-C had left the medication for FM-A to administer and stated, "That is not our policy. I will be working at correcting that." DON stated she held a staff meeting about three weeks prior, specifically addressing this issue, but was not sure why it continued to occur. Review of the facility's policy, Pharmaceutical (Medication) Administration Policy, revised 11/17, included "Medications shall be administered by licensed medical/nursing personnel or a trained medication aide under the supervision of a licensed nurse...Each resident has a right to self-administer drugs as determined by the Interdisciplinary Team as safe practice. The physician and the licensed nurse using an assessment of physical, visual and cognitive ability make this determination during the assessment period."	F 658		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		6/1/18

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F 686	Continued From page 16 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess a new and declining pressure ulcer, and failed to provide care plan interventions including timely repositioning to promote healing and prevent worsening of pressure ulcers for 1 of 3 residents (R37) reviewed for pressure ulcers. R37 suffered actual harm when she developed 2 pressure ulcers on coccyx, one of which advanced to a stage III. Findings include: R37's quarterly Minimum Data Sets (MDS), dated 4/2/18, indicated R37 was at risk for pressure ulcers (localized injury to the skin and or underlying tissue, usually over a bony prominence), however, did not have any pressure ulcers at the time of the assessment. The MDS indicated use of a pressure reducing mattress on the bed, pressure reducing cushion on her Broda wheel chair (reclining wheel chair with taller back and elevating leg rest) and indicated R37 was on a repositioning program, and had interventions to decrease risk for developing pressure ulcers. R37's MDS, further indicated severe cognitive impairment and required extensive assist of two for bed mobility and transfers. R37's Care Area Assessment (CAA), dated 10/6/17, indicated R37 was confined to a bed or chair most of the time, needed a special mattress or seat cushion to reduce or relieve pressure and required a regular schedule of turning to relieve	F 686	Immediate plan of correction: R37 assessed by RN on 4-26-18. New interventions were implemented immediately which include: cleanse ulcer with wound cleanser, apply no sting barrier film to surrounding skin, and cover with sacral foam dressing each shift. Foam dressing to be changed every 3 days and as needed. The MD was updated via fax on 4-26-18 of declining skin integrity. A Comprehensive Skin Assessment with Braden was performed and care plan reviewed and updated on 4-26-18. Hospice was updated and an alternating low loss air mattress was put in place on 4-27-18. Identification of other residents Skin observations completed to assure no other residents with open areas; New comprehensive skin assessment with Braden Scale will be completed on all residents in facility. Measures put in place Repositioning audits will be conducted randomly each week X 4 weeks and then randomly X 2 months to ensure compliance with following care plans. Review of following care plans was done at NAR meeting on 5-15-18. All repositioning care plans will be reviewed for all residents to ensure repositioning timeframe indicated on care plan is appropriate. An inservice	

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F 686	Continued From page 17 pressure. R37 resident profile printed 4/26/18, identified diagnoses: of encounter for palliative care, Alzheimer's disease with early onset, dementia, and end of life psychosis. R37 care plan, dated 4/10/17, identified R37 was at risk for pressure ulcers. The goals included 1.) skin will remain intact 2). will not develop any new skin concerns 3). will have needs met and remain comfortable. Interventions included, skin check with weekly bath, pressure ulcer assessment, skin assessment with tissue tolerance assessment per nursing home policy, Braden scale, podiatry exams as needed, keep linens clean, dry and wrinkle free, keep skin clean and dry, and minimize skin exposure to moisture. On 3/30/18, new interventions included, pressure relieving cushion in Broda wheel chair, and heel protectors on when in bed. Nursing Aide Care Sheet, undated, indicated R37 should be turned and repositioned every two hours, have a pressure relieving cushion in her Broda wheelchair, heel protectors on at night, and be toileted upon rising, after meals and every two to three hours while awake during the day. Night shift to check and change every two hours. -Progress note, dated 4/6/18, at 3:31 p.m. indicated registered nurse (RN)-A documented an open area to coccyx that measured 0.8 centimeters (cm) x 0.4 cm. Resident stated, "It smarts right there." Will start calmoseptine cream to be applied once a shift until healed. The progress note indicated presence of a pressure ulcer, however, the record lacked evidence that an assessment was completed to determine	F 686	presented by consulting Wound Care Specialist for Licensed nurses and NARs is scheduled on 5-17-18 to review skin care protocols. Licensed nurses are assigned Relias education on Pressure Injury Assessment, Interventions and Prevention. Monitoring mechanisms Repositioning audits will be conducted randomly each week X 4 weeks and then randomly X 2 months to ensure compliance with following care plans. Residents with new pressure injuries will have their charts audited to ensure comprehensive skin assessment was completed in a timely manner. These audits will be conducted for the next 2 months on all residents with any new facility acquired pressure injuries. Results of audits will be reviewed by the QAPI committee. Person responsible: Director of Nursing Date of completion: 6-1-18	

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factors that caused the newly developed pressure ulcer.
-Progress note, dated 4/13/18, at 10:42 a.m. indicated licensed practical nurse (LPN)-A documented R37 has a superficial open area, roughly 1 cm round to her right butt cheek, barrier cream applied.
-Progress note, dated 4/17/18, indicated hospice was at facility and has no changes or concerns at this time. Hospice nurse updated on pressure ulcer and no change in plan of care for skin treatment. The note further indicated that the hospice nurse stated she would update MD with any changes.
-Progress note, dated 4/20/18, at 1:24 p.m. RN-A documented pressure area on coccyx has declined, was one area of concern, now is two areas on both sides of coccyx. See Wound Management. Will start stoma powder and calmoseptine to be completed by nurses. The progress note indicated worsening of the pressure ulcer and development of a second pressure area on coccyx, however, the chart lacked evidence that an assessment or evaluation was completed to determine and address what caused the decline.

Wound Management form, dated 4/20/18, RN-A indicated a right side pressure ulcer on coccyx with measurements of length- 1.6 cm by width- 0.5 cm , a stage I pressure ulcer. (intact skin with non-blanchable redness of a localized area over a bony prominence)

Wound Management form, dated 4/20/18 by RN-A indicated a pressure ulcer on left of coccyx. Length is 1 cm by width 0.4 cm, a stage I pressure ulcer. Comments indicated on left side coccyx started stoma powder and calmoseptine.

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Treatment Administration History record, dated 4/6/18 through 4/20/18, indicated to check coccyx open area every shift and ensure calmoseptine cream barrier is applied to area at least once a shift by nursing assistance.

During continuous observation, on 4/25/18, starting at 7:12 a.m. R37 was up in Broda wheelchair sitting at table with one other resident in the lobby/common area. At 7:43 a.m. R37 was wheeled to dining room for breakfast. R37 was served breakfast and was provided some assistance with eating. Following breakfast, a nursing assistant wheeled R37 in Broda chair to common area, up to a table where she had been sitting prior to breakfast. At 9:02 a.m. R37 was wheeled in Broda chair by activity aid (AA)-A to a table in the art room. No attempt was made to reposition or toilet R37 since the start of the continuous observation. R37 sat alone at the table in the art room with head down, and eyes closed. AA-A greeted R37, however, eyes remain closed, with head bent forward, and appeared to be sleeping. R37 did not participate, rather just sat in her chair at the table with eyes closed. At 10:41 a. m. R37 was wheeled to the common room/lobby to a table with other residents. At 10:43 a.m. in common room/lobby, nursing assistant (NA)-A explained R37's routine cares. NA-A further stated R37 has a low bed with a mat next to bed, is limited assist with dressing, denture cares, hair in morning, and washing up and needs help with incontinence, so is washed up and provided a clean brief and is helped with repositioning. NA-A stated she cares for R37 quite a bit as she is on her wing and went on to state that R37 is total care. NA-A stated, "I don't know what time R37 was last repositioned, but I

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can go look." NA-A stated [R37] was repositioned at 6:50 a.m. when she got her up this morning. At 11:02 a. m. that same day, R37 remained in Broda chair, slumped over, eyes closed in common lounge room. R37 had not been repositioned or toileted since 6:50 a.m., over four hours, rather than the every two hours as directed per the Nursing Assistant Care Sheet.

During interview, on 4/25/18, at 12:02 p.m. the director of nursing (DON) stated R37 should be toileted upon rising, after breakfast, after lunch, at HS (hours of sleep) and every 2-3 hours while awake. The DON stated R37 care plan indicated reposition every 2 hours or as needed. DON stated her expectation is that the nurses follow the care plan.

During observation, on 4/25/18, at 12:19 p.m. the DON entered the dining room, wheeled R37 out of dining room to hallway and stopped to talk to two NAs. The two NAs then wheeled R37 to her room. At 12:22 p.m. NA-B and NA-C assisted R37 to stand and to transfer to the toilet. Due to R37's position in the bathroom, it was difficult to visualize the pressure ulcers at this time.

During interview, on 4/25/18, at 12:55 p.m. RN-A stated she looks at wounds weekly, and the other LPNs or RNs look every shift. RN-A stated the NAs should report any changes if ulcers are getting worse, if not, no report is needed. RN-A stated NAs should tell a nurse if there are changes from shift to shift and to see if ulcers remain stable. RN-A stated hospice is here 2 times weekly, and they let the physician know if changes have occurred and if wound is worse. RN-A further stated they at times utilize a consultant wound nurse out of Litchfield,

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however, R37 was not referred to the consultant wound nurse. RN-A stated R37 had first developed a pressure ulcer about a month ago on the right side of coccyx. At 1:13 p.m. R37 was laid down in bed on her left side. RN-A stated the ulcer on the left coccyx is larger than it looked on Friday, and the right ulcer is smaller. RN-A stated, "I am sure my measurements will be bigger." RN-A measured the wounds and stated finding included: left side is 2.6 cm x 1 cm and into second layer of skin, not really slough (non-viable, yellow, gray, tan or brown tissue in the wound bed) but becoming slough, and getting deeper, and that the yellow was not there on Friday. RN-A further stated R37 needed to lay down, and get off her bottom. RN-A went on to say right side wound is superficial, 0.4 x 0.4., left side is a stage II (partial thickness loss of skin, presenting as a shallow open ulcer, the wound bed is viable pink or red. Granulation, slough and eschar are not present) and right side is stage I, but epithelial tissue, and very fragile, not granulation", (pink, red moist tissue that fills an open wound) that R37 had treatment powder first and cream next. RN-A then stated she would look into more aggressive treatment, and be changing treatment as wound had changed. RN-A added, "I will want the nursing assistants to lay her down more." RN-A cleansed her coccyx and applied barrier cream. R37 agreed to lay on left side as RN-A stated, " your bottom is pretty sore."

Progress note, dated 4/25/18, at 1:49 p.m. indicated RN-A measured pressure ulcer to coccyx area and areas have declined. Fax sent to update rounding MD. Called hospice and left message updating. Will encourage resident to lay down and turn side to side. Have been updating hospice on skin issue and have no new orders

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from them. Will change treatment to bottom If MD recommends something else and will change order.

During interview on 4/25/18 at 2:02 p.m. RN-A indicated the yellow area on R37's left of coccyx is 40% slough.

During interview at 2:18 p.m. RN-A was reviewing the staging tool she reported she used for staging a pressure ulcer. After reviewing the tool, RN-A indicated due to the slough, the pressure ulcer should be staged as a stage III. (full thickness, loss of skin in which subcutaneous fat may be visible. Slough may be visible but does not obscure the depth of the tissue) She also indicated the NAs should be repositioning R37 every 2 hours.

Wound Management form, dated 4/25/18 at 1:45 p.m. indicated a pressure ulcer on coccyx, length- 2.6 cm, width- 1 cm, stage II pressure ulcer. Comments indicated, stoma powder and calmoseptine cream. On same date, at 2:28 p.m. coccyx pressure ulcer is documented as length 2.6 cm by width 1 cm, a stage III pressure ulcer. Comments indicate, will apply new foam dressing to area.

On 4/25/18 Treatment Administration History Record, indicated to check dressing to coccyx every shift, change dressing every three day and as needed. Cleanse ulcer with wound cleanser, apply no sting barrier film to surrounding skin, and cover with sacral foam dressing.

Writer placed a phone call to MD, rounding physician for this facility, on 4/26/18, at 8:05 a.m. and message was left regarding the above. No

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phone call was returned.

On 4/26/18, at 12:42 p.m. RN-A documented she had spoken to the hospice nurse regarding air mattress and one has been ordered for R37. Hospice nurse updated on new foam sacral dressing as of 4/25/18 and hospice nurse indicated she will update the MD. Continue to encourage R37 to lay on side in bed at least once a day as R37 likes to be up in her chair.

R37's care plan, was updated on 4/26/18, and included a new goal of 1) current pressure ulcer will heal without issues. On this same date, a new intervention included 1. complete treatments 2). follow repositioning plan 3). monitor for changes in condition and update medical doctor and hospice as needed.

From 4/6/18 to 4/20/18, 2 new pressure ulcers developed. Interventions included applying cream and powder to bottom, however, the record did not indicate an assessment was completed to determine root cause of the pressure ulcers or that any new pressure ulcer interventions were put into place to prevent worsening or the development of new ulcers until 4/26/18 when R37 developed a stage III pressure ulcer.

Lake Side Health Care of Dassel Skin Care Program Policy, indicates A resident who enters an Augustana facility will not develop a pressure injury unless the individuals clinical condition demonstrates, and a physician or NP authenticates, that it was unavoidable. A resident who has a pressure injury will receive the necessary treatment and services to promote healing, prevent infections, and prevent new injury's from developing. Any alteration in skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245533	A. BUILDING _____ B. WING _____	04/26/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE HEALTH CARE CENTER	439 WILLIAM AVENUE EAST, PO BOX 383 DASSEL, MN 55325

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 24 integrity will be communicated to the resident's physician and family. Treatments will be ordered by physician/NP or by utilizing facility wound care protocols.	F 686		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure accurate blood pressure parameters were followed when administering the hypertensive (high blood pressure) medication for 1 of 5 residents (R8) reviewed for unnecessary medications.	F 757	Immediate plan of correction□: Notified physician for R8 on 4-26-18 of metoprolol being administered to resident and blood pressure parameters were not followed with administration. Response from physician on 4-27-18 stated to change parameters to hold if Systolic blood	6/1/18

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F 757	Continued From page 25 Findings include: R8's Minimum Data Set (MDS), dated 2/9/18, identified R8 was cognitively intact with active diagnoses of heart failure, diabetes mellitus, and hypertension (high blood pressure). R8's current physician orders, printed 4/26/18, identified R8 took several medications, including but not limited to, the following medication: -metoprolol succinate extended release (antihypertensive medication) 12.5 mg once daily in the morning for heart failure, with special instructions, "administer with food. Hold metoprolol if BP [blood pressure] below 120/65. goal for BP should be 130 systolic [maximum pressure during one heart beat, noted as top number] and diastolic [minimum pressure in between two heart beats, noted as bottom number] <90." This order was started 3/16/18. R8's medication administration record (MAR), from 4/1/18 to 4/26/18, identified: -On 4/1/18, R8's BP was 104/62. Although R8's BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given. -On 4/2/18, R8's BP was 112/64. Although R8's BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given. -On 4/7/18, R8's BP was 104/58. Although R8's BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given. -On 4/15/18, R8's BP was 118/64. Although R8's BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given.	F 757	pressure is <120 or diastolic blood pressure is <65. Identification of other residents -- Audit of other residents was completed to see if any have parameters were not being followed as ordered. Measures put in place-- Education of licensed nursing staff regarding following parameters for administration completed on 5-10-18 at nurses meeting. Reviewed protocol to update physician if BP regularly falling outside of parameters for administration. Monitoring mechanisms Consulting pharmacist updated and will audit medications with parameters with monthly review and make suggestions based on that review. Results of audits will be reviewed by the QAPI committee Person responsible: Director of Nursing Date of Completion: 6-1-2018	

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F 757	Continued From page 26	F 757		

-On 4/16/18, R8's BP was 110/50. Although R8's BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given.
-On 4/18/18, R8's BP was 113/72. Although R8's BP was above the parameters ordered for diastolic blood pressure, R8's MAR had initials in the box, indicating the metoprolol was held.
-On 4/19/18, R8's BP was 105/68. Although R8's BP was below the parameters ordered for systolic blood pressure, R8's MAR had initials in the box, indicating the metoprolol was given.
-On 4/20/18, R8's BP was 112/68. Although R8's BP was above the parameters ordered for diastolic blood pressure, R8's MAR had initials in the box, indicating the metoprolol was held.
-On 4/26/18, R8's BP was 115/74. Although R8's BP was above the parameters ordered for diastolic blood pressure, R8's MAR had initials in the box, indicating the metoprolol was held.

R8's record identified he had inconsistently received metoprolol succinate outside of the ordered parameters, or it had been held when it should have been given.

During an observation and interview on 4/26/18, at 10:17 a.m. R8 was seated in a chair in his room. R8 stated he used a wheelchair or a four-wheeled walker for locomotion, and although he had a history of falling, denied feeling dizzy when ambulating or transferring.

Consultant Pharmacist's Drug Regimen Reviews, on 10/4/17, included, "Just FYI [for your information] we have hold parameter directions to hold metoprolol for BP below 120/65 which at times if is minimally below this, thus [increased] BP at next BP check. Should we D/C

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F 757	Continued From page 27	F 757		

[discontinue] this parameter or adjust it at all?" A note written in the margin included, "10/13/17 per MD [medical doctor] not at this time."

During an interview on 4/26/18, at 10:49 a.m. registered nurse (RN)-A stated she was not aware that R8's metoprolol had been held several times in the month of 4/18 due to BP being low, either systolic or diastolic, per ordered parameters, and on five occasions, was given metoprolol even though the systolic and diastolic BP were both lower than the ordered parameters and should have been held. RN-A stated she did not have time to check on each resident's medications every day and was not made aware of this. RN-A stated R8's physician had not been notified.

In a follow up interview on 4/26/18, at 11:21 a.m. RN-A stated she was unclear what the ordered parameters meant, if staff were to hold the metoprolol if the BP was less than 120 systolic, or less than less than 65, or both systolic and diastolic needed to be less than 120/65 to hold it. RN-A stated the parameter order was unclear and verified that staff were inconsistently interpreting whether or not the metoprolol should be given, therefore, there was a potential for error. RN-A stated, "That's all on me." RN-A stated she would be notifying R8's physician and would be clarifying the parameters for R8's BP and when the metoprolol should be held.

During an interview on 4/26/18, at 1:46 p.m. consultant pharmacist (CP) stated, "I can tell you that our expectations include parameters that are clear, for example, if it's systolic, diastolic, or both. There's likely unclear nursing directions." CP stated she had questioned R8's physician

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F 757	Continued From page 28 regarding the parameters and questioned the intention and whether the parameters needed to be adjusted, however, she trusted the physician's response of not wanting to adjust it at that time due to R8's other medical conditions. CP stated, "I do look at the vitals. All patients will have a baseline BP. We look at trends instead of outliers and if there are symptoms of any clinical response or unwanted consequences." CP also stated, "I have identified parameters and holding medication in our QA [quality assurance] reports in January and April. This is something that needs to be improved. We are working on this." Review of the facility's policy, Pharmaceutical (Medication) Administration Policy, revised 11/17, included, "All medication will be given per physicians order." The policy lacked direction for holding medications per ordered parameters or clarifying parameter orders if unclear.	F 757		

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	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/25/2018**

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LAKESIDE HEALTH CARE CENTER	**439 WILLIAM AVENUE EAST, PO BOX 383** **DASSEL, MN 55325**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. 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 Health Care Center was found to be 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 DEFICIENCIES (K-TAGS) TO:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/16/2018

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

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K 000	Continued From page 1 Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@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 Health Care Center is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1978, an addition was constructed and was determined to be of Type II(111) construction. In 1984, an addition was constructed and was determined to be of Type II(111) construction. The most recent addition was constructed in 1993 and was determined to be of Type II(111) construction. Because the original building and the 3 additions met the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a	K 000		

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K 000	Continued From page 2 fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 44 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and a staff interview, it could not be verified whether the facility's general ventilating and air conditioning system (HVAC) was maintained in accordance with NFPA 101 (2012) Chapter 19, Section 19.5.2.1 and Chapter 9, Section 9.1 and NFPA 90A. In a fire emergency, a noncompliant HVAC system could adversely affect all residents. FINDINGS INCLUDE: On 04/25/2018 at 10 AM, during an interview with facility staff, it was confirmed the HVAC system does contain one or more fire/smoke dampers,	K 521	It is the practice of this facility to maintain our HVAC system in accordance with NFPA 101, Chapter 19.5.2.1. which needs to be tested every four years. All residents have the potential; to be affected, however there was not actual harm. Maintenance Supervisor and or designee will be re-educated by Administrator on frequency of the testing of the HVAC dampers. The work order was added to Maintenance Care an electronic work order system. On April 30thth 2018 AEM Mechanical Services tested out fire dampers.	6/1/18

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K 521	Continued From page 3 however, no fire/smoke dampers were inspected and tested within the previous 4 years, in accordance with NFPA 90A [1999] Chapter 3, Section 3-4.7. This deficient practice was verified by the Facility Maintenance Director.	K 521		
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 record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all residents and an undetermined amount of staff and visitors. Findings include: On facility tour between 9 AM and 1:00 PM on 04/25/2018, documentation reviewed revealed	K 712	It is the practice of this facility to hold fire drills at unexpected times under varying condition, at least quarterly on each shift. All residents and visitors have the potential to be affected, however, there was no actual harm. Maintenance Supervisor and or designee will be re-educated by Administrator and or designee on frequency of varying times of fire drills on each shift. These fire drills will be monitored by Administrator and or designee and taken to monthly safety committee for 6 months.	6/1/18

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K 712	Continued From page 4 that Fire drills were not performed during these times: 1) 1st quarter 3rd shift of 2018 2) 2nd quarter 3rd shift 3) 3rd quarter 1st shift of 2017 4) 4th quarter 2nd shift of 2017 This deficient practice was verified by the Facility Maintenance Director.	K 712		

Electronically delivered
May 10, 2018

Ms. Brianne Wolters, Administrator
Lakeside Health Care Center
439 William Avenue East, PO Box 383
Dassel, MN 55325

Re: State Nursing Home Licensing Orders - Project Number S5533027

Dear Ms. Wolters:

The above facility was surveyed on April 23, 2018 through April 26, 2018 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. 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 Kathleen Lucas, Unit Supervisor at (320) 223-7343 or kathleen.lucas@state.mn.us.

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,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@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
	00773	A. BUILDING: _____ B. WING _____	04/26/2018

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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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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	00773	A. BUILDING: _____ B. WING _____	04/26/2018

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LAKESIDE HEALTH CARE CENTER	439 WILLIAM AVENUE EAST, PO BOX 383 DASSEL, MN 55325

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 4/23/18 through 4/26/18 surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A	2 000		

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2 000	Continued From page 2 PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 005	MN Rule 4658.0015 COMPLIANCE WITH REGULATIONS AND STANDARDS A nursing home must operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in a nursing home. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow standards of practice related to medication administration for 1 of 1 residents (R38) observed to receive medications during the evening meal, when medications were left with the family member to administer that were to administered by a licensed nurse. Findings include: R38's resident face sheet, dated 1/10/17, identified diagnoses including dementia without behavioral disturbance, legal blindness, and generalized muscle weakness. R38's quarterly Minimum Data Set (MDS), dated 4/12/18, identified R38 had severe cognitive impairment and required extensive assistance for all activities of daily living, including eating.	2 005	Immediate plan of correction-- 1:1 coaching/education of nurse was done; spoke with R38□s daughter to review policy regarding medication administration that the licensed nurse should administer medications. Identification of other residents□Isolated incident, no other residents involved. Measures put in place□education of nursing staff was completed at nurses meeting on 5-10-18. All nurses were assigned review of Medication Pass Protocol course in Relias, re-education of staff member involved was completed. Monitoring mechanisms Random medication pass audits will be completed with licensed staff X 2 months to ensure staff are following proper	6/1/18

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2 005	Continued From page 3 R38's care plan, dated 4/10/18, included R38 had impaired cognition with diagnosis of dementia, was hard of hearing, and was legally blind. Further included, R38 was not able to make her needs/wants known consistently and had severe cognitive impairment. During a family interview on 4/23/18, at 6:21 p.m. in the dining room, R38's family member (FM)-A was assisting R38 to eat and requested to complete the interview while R38 continued to eat. Licensed practical nurse (LPN)-C walked into the dining room, carrying a medication cup that contained applesauce with a powdered white substance mixed in. FM-A stated, "She's not quite done yet," and directed LPN-C to "just leave it," and stated she would make sure R38 took the medication. FM-A stated, "It's just a blood pressure pill and one for her heart." LPN-C set the cup on the table in front of R38, and left the dining room. FM-A stated, "They do that in the mornings too. She's a slow eater. I just tell them to leave it and I'll get it down her." FM-A indicated she always gave R38 her medications before she was admitted to the facility. At 6:47 p.m. the medication cup remained on the table while R38 continued to eat with assistance from FM-A. At 6:57 p.m. FM-A spooned the contents of the medication cup into R38's mouth and wheeled her out of the dining room. When interviewed on 4/23/18, at 7:28 p.m. LPN-C indicated if residents were alert and capable of taking their own medications, he would leave them for them to take, however, LPN-C stated someone with dementia or a stroke wasn't able to do that, so "we would wait with them until they swallow the medication." LPN-C stated, "For example, [R38], [FM-A] wants us to leave it on the table until she is done. If the family wants to	2 005	medication pass procedure. Results of audits will be reviewed by the QAPI committee Person responsible: Director of Nursing Date of completion: 6-1-18	

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2 005	Continued From page 4	2 005		

give, we can leave it." When asked what the facility policy was regarding leaving medications for the resident to take or for the family to administer, LPN-C stated, "If the family wants to give the medication, we leave it, otherwise we don't have a policy to leave the medications. I had [FM-A's] permission to leave it." LPN-C verified the medications he left for FM-A to administer was carvedilol (used to treat congestive heart failure) and isosorbide dinitrate (used to treat heart failure and chest pain). LPN-C stated, "I always go there and check that they are taken. Tonight, I didn't, because [surveyor] were there."

Review of R38's Physician Order Report, copied 4/26/18, included carvedilol 3.125 milligrams (mg) twice daily with food, and isosorbide dinitrate 20 mg twice daily.

R38's Self Administration of Medications assessment, dated 1/11/17, identified R38 was "unable to understand the concept of self-administration of medications."

When interviewed on 4/24/18, at 9:27 a.m. director of nursing (DON) stated she was aware that LPN-C had left the medication for FM-A to administer and stated, "That is not our policy. I will be working at correcting that." DON stated she held a staff meeting about three weeks prior, specifically addressing this issue, but was not sure why it continued to occur.

Review of the facility's policy, Pharmaceutical (Medication) Administration Policy, revised 11/17, included "Medications shall be administered by licensed medical/nursing personnel or a trained medication aide under the supervision of a licensed nurse...Each resident has a right to self-administer drugs as determined by the

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2 005	Continued From page 5 Interdisciplinary Team as safe practice. The physician and the licensed nurse using an assessment of physical, visual and cognitive ability make this determination during the assessment period." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures and provide education on approved standards of practice related to medication administration procedures. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	2 005		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.	2 900		6/1/18

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2 900	Continued From page 6 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess a new and declining pressure ulcer, and failed to provide care plan interventions including timely repositioning to promote healing and prevent worsening of pressure ulcers for 1 of 3 residents (R37) reviewed for pressure ulcers. R37 suffered actual harm when she developed 2 pressure ulcers on coccyx, one of which advanced to a stage III. Findings include: R37's quarterly Minimum Data Sets (MDS), dated 4/2/18, indicated R37 was at risk for pressure ulcers (localized injury to the skin and or underlying tissue, usually over a bony prominence), however, did not have any pressure ulcers at the time of the assessment. The MDS indicated use of a pressure reducing mattress on the bed, pressure reducing cushion on her Broda wheel chair (reclining wheel chair with taller back and elevating leg rest) and indicated R37 was on a repositioning program, and had interventions to decrease risk for developing pressure ulcers. R37's MDS, further indicated severe cognitive impairment and required extensive assist of two for bed mobility and transfers. R37's Care Area Assessment (CAA), dated 10/6/17, indicated R37 was confined to a bed or chair most of the time, needed a special mattress or seat cushion to reduce or relieve pressure and required a regular schedule of turning to relieve pressure. R37 resident profile printed 4/26/18, identified diagnoses: of encounter for palliative care,	2 900	Immediate plan of correction: R37 assessed by RN on 4-26-18. New interventions were implemented immediately which include: cleanse ulcer with wound cleanser, apply no sting barrier film to surrounding skin, and cover with sacral foam dressing each shift. Foam dressing to be changed every 3 days and as needed. The MD was updated via fax on 4-26-18 of declining skin integrity. A Comprehensive Skin Assessment with Braden was performed and care plan reviewed and updated on 4-26-18. Hospice was updated and an alternating low loss air mattress was put in place on 4-27-18. Identification of other residents Skin observations completed to assure no other residents with open areas; New comprehensive skin assessment with Braden Scale will be completed on all residents in facility. Measures put in place Repositioning audits will be conducted randomly each week X 4 weeks and then randomly X 2 months to ensure compliance with following care plans. Review of following care plans was done at NAR meeting on 5-15-18. All repositioning care plans will be reviewed for all residents to ensure repositioning timeframe indicated on care plan is appropriate. An inservice presented by consulting Wound Care Specialist for Licensed nurses and NARs is scheduled on 5-17-18 to review skin care protocols. Licensed nurses are	

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2 900	Continued From page 7 Alzheimer's disease with early onset, dementia, and end of life psychosis. R37 care plan, dated 4/10/17, identified R37 was at risk for pressure ulcers. The goals included 1.) skin will remain intact 2). will not develop any new skin concerns 3). will have needs met and remain comfortable. Interventions included, skin check with weekly bath, pressure ulcer assessment, skin assessment with tissue tolerance assessment per nursing home policy, Braden scale, podiatry exams as needed, keep linens clean, dry and wrinkle free, keep skin clean and dry, and minimize skin exposure to moisture. On 3/30/18, new interventions included, pressure relieving cushion in Broda wheel chair, and heel protectors on when in bed. Nursing Aide Care Sheet, undated, indicated R37 should be turned and repositioned every two hours, have a pressure relieving cushion in her Broda wheelchair, heel protectors on at night, and be toileted upon rising, after meals and every two to three hours while awake during the day. Night shift to check and change every two hours. -Progress note, dated 4/6/18, at 3:31 p.m. indicated registered nurse (RN)-A documented an open area to coccyx that measured 0.8 centimeters (cm) x 0.4 cm. Resident stated, "It smarts right there." Will start calmoseptine cream to be applied once a shift until healed. The progress note indicated presence of a pressure ulcer, however, the record lacked evidence that an assessment was completed to determine factors that caused the newly developed pressure ulcer. -Progress note, dated 4/13/18, at 10:42 a.m. indicated licensed practical nurse (LPN)-A documented R37 has a superficial open area,	2 900	assigned Relias education on Pressure Injury Assessment, Interventions and Prevention. Monitoring mechanisms Repositioning audits will be conducted randomly each week X 4 weeks and then randomly X 2 months to ensure compliance with following care plans. Residents with new pressure injuries will have their charts audited to ensure comprehensive skin assessment was completed in a timely manner. These audits will be conducted for the next 2 months on all residents with any new facility acquired pressure injuries. Results of audits will be reviewed by the QAPI committee. Person responsible: Director of Nursing Date of completion: 6-1-18	

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2 900	Continued From page 8 roughly 1 cm round to her right butt cheek, barrier cream applied. -Progress note, dated 4/17/18, indicated hospice was at facility and has no changes or concerns at this time. Hospice nurse updated on pressure ulcer and no change in plan of care for skin treatment. The note further indicated that the hospice nurse stated she would update MD with any changes. -Progress note, dated 4/20/18, at 1:24 p.m. RN-A documented pressure area on coccyx has declined, was one area of concern, now is two areas on both sides of coccyx. See Wound Management. Will start stoma powder and calmoseptine to be completed by nurses. The progress note indicated worsening of the pressure ulcer and development of a second pressure area on coccyx, however, the chart lacked evidence that an assessment or evaluation was completed to determine and address what caused the decline. Wound Management form, dated 4/20/18, RN-A indicated a right side pressure ulcer on coccyx with measurements of length- 1.6 cm by width- 0.5 cm , a stage I pressure ulcer. (intact skin with non-blanchable redness of a localized area over a bony prominence) Wound Management form, dated 4/20/18 by RN-A indicated a pressure ulcer on left of coccyx. Length is 1 cm by width 0.4 cm, a stage I pressure ulcer. Comments indicated on left side coccyx started stoma powder and calmoseptine. Treatment Administration History record, dated 4/6/18 through 4/20/18, indicated to check coccyx open area every shift and ensure calmoseptine cream barrier is applied to area at least once a shift by nursing assistance.	2 900		

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2 900	Continued From page 9 During continuous observation, on 4/25/18, starting at 7:12 a.m. R37 was up in Broda wheelchair sitting at table with one other resident in the lobby/common area. At 7:43 a.m. R37 was wheeled to dining room for breakfast. R37 was served breakfast and was provided some assistance with eating. Following breakfast, a nursing assistant wheeled R37 in Broda chair to common area, up to a table where she had been sitting prior to breakfast. At 9:02 a.m. R37 was wheeled in Broda chair by activity aid (AA)-A to a table in the art room. No attempt was made to reposition or toilet R37 since the start of the continuous observation. R37 sat alone at the table in the art room with head down, and eyes closed. AA-A greeted R37, however, eyes remain closed, with head bent forward, and appeared to be sleeping. R37 did not participate, rather just sat in her chair at the table with eyes closed. At 10:41 a. m. R37 was wheeled to the common room/lobby to a table with other residents. At 10:43 a.m. in common room/lobby, nursing assistant (NA)-A explained R37's routine cares. NA-A further stated R37 has a low bed with a mat next to bed, is limited assist with dressing, denture cares, hair in morning, and washing up and needs help with incontinence, so is washed up and provided a clean brief and is helped with repositioning. NA-A stated she cares for R37 quite a bit as she is on her wing and went on to state that R37 is total care. NA-A stated, "I don't know what time R37 was last repositioned, but I can go look." NA-A stated [R37] was repositioned at 6:50 a.m. when she got her up this morning. At 11:02 a. m. that same day, R37 remained in Broda chair, slumped over, eyes closed in common lounge room. R37 had not been repositioned or toileted since 6:50 a.m., over four hours, rather than the every two hours as directed	2 900		

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2 900	Continued From page 10 per the Nursing Assistant Care Sheet. During interview, on 4/25/18, at 12:02 p.m. the director of nursing (DON) stated R37 should be toileted upon rising, after breakfast, after lunch, at HS (hours of sleep) and every 2-3 hours while awake. The DON stated R37 care plan indicated reposition every 2 hours or as needed. DON stated her expectation is that the nurses follow the care plan. During observation, on 4/25/18, at 12:19 p.m. the DON entered the dining room, wheeled R37 out of dining room to hallway and stopped to talk to two NAs. The two NAs then wheeled R37 to her room. At 12:22 p.m. NA-B and NA-C assisted R37 to stand and to transfer to the toilet. Due to R37's position in the bathroom, it was difficult to visualize the pressure ulcers at this time. During interview, on 4/25/18, at 12:55 p.m. RN-A stated she looks at wounds weekly, and the other LPNs or RNs look every shift. RN-A stated the NAs should report any changes if ulcers are getting worse, if not, no report is needed. RN-A stated NAs should tell a nurse if there are changes from shift to shift and to see if ulcers remain stable. RN-A stated hospice is here 2 times weekly, and they let the physician know if changes have occurred and if wound is worse. RN-A further stated they at times utilize a consultant wound nurse out of Litchfield, however, R37 was not referred to the consultant wound nurse. RN-A stated R37 had first developed a pressure ulcer about a month ago on the right side of coccyx. At 1:13 p.m. R37 was laid down in bed on her left side. RN-A stated the ulcer on the left coccyx is larger than it looked on Friday, and the right ulcer is smaller. RN-A stated, "I am sure my measurements will be bigger."	2 900		

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2 900	Continued From page 11	2 900		

RN-A measured the wounds and stated finding included: left side is 2.6 cm x 1 cm and into second layer of skin, not really slough (non-viable, yellow, gray, tan or brown tissue in the wound bed) but becoming slough, and getting deeper, and that the yellow was not there on Friday. RN-A further stated R37 needed to lay down, and get off her bottom. RN-A went on to say right side wound is superficial, 0.4 x 0.4., left side is a stage II (partial thickness loss of skin, presenting as a shallow open ulcer, the wound bed is viable pink or red. Granulation, slough and eschar are not present) and right side is stage I, but epithelial tissue, and very fragile, not granulation", (pink, red moist tissue that fills an open wound) that R37 had treatment powder first and cream next. RN-A then stated she would look into more aggressive treatment, and be changing treatment as wound had changed. RN-A added, "I will want the nursing assistants to lay her down more." RN-A cleansed her coccyx and applied barrier cream. R37 agreed to lay on left side as RN-A stated, " your bottom is pretty sore."

Progress note, dated 4/25/18, at 1:49 p.m. indicated RN-A measured pressure ulcer to coccyx area and areas have declined. Fax sent to update rounding MD. Called hospice and left message updating. Will encourage resident to lay down and turn side to side. Have been updating hospice on skin issue and have no new orders from them. Will change treatment to bottom If MD recommends something else and will change order.

During interview on 4/25/18 at 2:02 p.m. RN-A indicated the yellow area on R37's left of coccyx is 40% slough.

During interview at 2:18 p.m. RN-A was reviewing

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2 900	Continued From page 12 the staging tool she reported she used for staging a pressure ulcer. After reviewing the tool, RN-A indicated due to the slough, the pressure ulcer should be staged as a stage III. (full thickness, loss of skin in which subcutaneous fat may be visible. Slough may be visible but does not obscure the depth of the tissue) She also indicated the NAs should be repositioning R37 every 2 hours. Wound Management form, dated 4/25/18 at 1:45 p.m. indicated a pressure ulcer on coccyx, length- 2.6 cm, width- 1 cm, stage II pressure ulcer. Comments indicated, stoma powder and calmoseptine cream. On same date, at 2:28 p.m. coccyx pressure ulcer is documented as length 2.6 cm by width 1 cm, a stage III pressure ulcer. Comments indicate, will apply new foam dressing to area. On 4/25/18 Treatment Administration History Record, indicated to check dressing to coccyx every shift, change dressing every three day and as needed. Cleanse ulcer with wound cleanser, apply no sting barrier film to surrounding skin, and cover with sacral foam dressing. Writer placed a phone call to MD, rounding physician for this facility, on 4/26/18, at 8:05 a.m. and message was left regarding the above. No phone call was returned. On 4/26/18, at 12:42 p.m. RN-A documented she had spoken to the hospice nurse regarding air mattress and one has been ordered for R37. Hospice nurse updated on new foam sacral dressing as of 4/25/18 and hospice nurse indicated she will update the MD. Continue to encourage R37 to lay on side in bed at least once a day as R37 likes to be up in her chair.	2 900		

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2 900	Continued From page 13 R37's care plan, was updated on 4/26/18, and included a new goal of 1) current pressure ulcer will heal without issues. On this same date, a new intervention included 1. complete treatments 2). follow repositioning plan 3). monitor for changes in condition and update medical doctor and hospice as needed. From 4/6/18 to 4/20/18, 2 new pressure ulcers developed. Interventions included applying cream and powder to bottom, however, the record did not indicate an assessment was completed to determine root cause of the pressure ulcers or that any new pressure ulcer interventions were put into place to prevent worsening or the development of new ulcers until 4/26/18 when R37 developed a stage III pressure ulcer. Lake Side Health Care of Dassel Skin Care Program Policy, indicates A resident who enters an Augustana facility will not develop a pressure injury unless the individuals clinical condition demonstrates, and a physician or NP authenticates, that it was unavoidable. A resident who has a pressure injury will receive the necessary treatment and services to promote healing, prevent infections, and prevent new injury's from developing. Any alteration in skin integrity will be communicated to the resident's physician and family. Treatments will be ordered by physician/NP or by utilizing facility wound care protocols. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary	2 900		

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2 900	Continued From page 14 treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing could educate on the importance of assessing with the development of pressure ulcers or worsening pressure ulcers to determine cause. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Seven (7) days.	2 900		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not	21535		6/1/18

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21535	Continued From page 15 subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure accurate blood pressure parameters were followed when administering the hypertensive (high blood pressure) medication for 1 of 5 residents (R8) reviewed for unnecessary medications. Findings include: R8's Minimum Data Set (MDS), dated 2/9/18, identified R8 was cognitively intact with active diagnoses of heart failure, diabetes mellitus, and hypertension (high blood pressure). R8's current physician orders, printed 4/26/18, identified R8 took several medications, including but not limited to, the following medication: -metoprolol succinate extended release (antihypertensive medication) 12.5 mg once daily in the morning for heart failure, with special instructions, "administer with food. Hold metoprolol if BP [blood pressure] below 120/65. goal for BP should be 130 systolic [maximum pressure during one heart beat, noted as top number] and diastolic [minimum pressure in between two heart beats, noted as bottom number] <90." This order was started 3/16/18. R8's medication administration record (MAR), from 4/1/18 to 4/26/18, identified: -On 4/1/18, R8's BP was 104/62. Although R8's BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given. -On 4/2/18, R8's BP was 112/64. Although R8's	21535	Immediate plan of correction: Notified physician for R8 on 4-26-18 of metoprolol being administered to resident and blood pressure parameters were not followed with administration. Response from physician on 4-27-18 stated to change parameters to hold if Systolic blood pressure is <120 or diastolic blood pressure is <65. Identification of other residents -- Audit of other residents was completed to see if any have parameters were not being followed as ordered. Measures put in place-- Education of licensed nursing staff regarding following parameters for administration completed on 5-10-18 at nurses meeting. Reviewed protocol to update physician if BP regularly falling outside of parameters for administration. Monitoring mechanisms Consulting pharmacist updated and will audit medications with parameters with monthly review and make suggestions based on that review. Results of audits will be reviewed by the QAPI committee Person responsible: Director of Nursing Completion Date: 6-1-18	

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21535	Continued From page 16 BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given. -On 4/7/18, R8's BP was 104/58. Although R8's BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given. -On 4/15/18, R8's BP was 118/64. Although R8's BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given. -On 4/16/18, R8's BP was 110/50. Although R8's BP was below the parameters ordered, R8's MAR had initials in the box, indicating the metoprolol was given. -On 4/18/18, R8's BP was 113/72. Although R8's BP was above the parameters ordered for diastolic blood pressure, R8's MAR had initials in the box, indicating the metoprolol was held. -On 4/19/18, R8's BP was 105/68. Although R8's BP was below the parameters ordered for systolic blood pressure, R8's MAR had initials in the box, indicating the metoprolol was given. -On 4/20/18, R8's BP was 112/68. Although R8's BP was above the parameters ordered for diastolic blood pressure, R8's MAR had initials in the box, indicating the metoprolol was held. -On 4/26/18, R8's BP was 115/74. Although R8's BP was above the parameters ordered for diastolic blood pressure, R8's MAR had initials in the box, indicating the metoprolol was held. R8's record identified he had inconsistently received metoprolol succinate outside of the ordered parameters, or it had been held when it should have been given. During an observation and interview on 4/26/18, at 10:17 a.m. R8 was seated in a chair in his room. R8 stated he used a wheelchair or a	21535		

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21535	Continued From page 17	21535		

four-wheeled walker for locomotion, and although he had a history of falling, denied feeling dizzy when ambulating or transferring.

Consultant Pharmacist's Drug Regimen Reviews, on 10/4/17, included, "Just FYI [for your information] we have hold parameter directions to hold metoprolol for BP below 120/65 which at times if is minimally below this, thus [increased] BP at next BP check. Should we D/C [discontinue] this parameter or adjust it at all?" A note written in the margin included, "10/13/17 per MD [medical doctor] not at this time."

During an interview on 4/26/18, at 10:49 a.m. registered nurse (RN)-A stated she was not aware that R8's metoprolol had been held several times in the month of 4/18 due to BP being low, either systolic or diastolic, per ordered parameters, and on five occasions, was given metoprolol even though the systolic and diastolic BP were both lower than the ordered parameters and should have been held. RN-A stated she did not have time to check on each resident's medications every day and was not made aware of this. RN-A stated R8's physician had not been notified.

In a follow up interview on 4/26/18, at 11:21 a.m. RN-A stated she was unclear what the ordered parameters meant, if staff were to hold the metoprolol if the BP was less than 120 systolic, or less than less than 65, or both systolic and diastolic needed to be less than 120/65 to hold it. RN-A stated the parameter order was unclear and verified that staff were inconsistently interpreting whether or not the metoprolol should be given, therefore, there was a potential for error. RN-A stated, "That's all on me." RN-A stated she would be notifying R8's physician and would be

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21535	Continued From page 18 clarifying the parameters for R8's BP and when the metoprolol should be held. During an interview on 4/26/18, at 1:46 p.m. consultant pharmacist (CP) stated, "I can tell you that our expectations include parameters that are clear, for example, if it's systolic, diastolic, or both. There's likely unclear nursing directions." CP stated she had questioned R8's physician regarding the parameters and questioned the intention and whether the parameters needed to be adjusted, however, she trusted the physician's response of not wanting to adjust it at that time due to R8's other medical conditions. CP stated, "I do look at the vitals. All patients will have a baseline BP. We look at trends instead of outliers and if there are symptoms of any clinical response or unwanted consequences." CP also stated, "I have identified parameters and holding medication in our QA [quality assurance] reports in January and April. This is something that needs to be improved. We are working on this." Review of the facility's policy, Pharmaceutical (Medication) Administration Policy, revised 11/17, included, "All medication will be given per physicians order." The policy lacked direction for holding medications per ordered parameters or clarifying parameter orders if unclear. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies as needed and provide education for following parameter set by physician including monitoring and reporting when parameters are outside of what the physician established for the resident. The DON or designee, could audit any/all resident's medical records, to ensure compliance	21535		

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21535	Continued From page 19 with following parameters. The DON or designee could take that information to QAPI to ensure compliance and determine the need for further education/monitoring/compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21535		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written	21880		6/1/18

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21880	Continued From page 20 grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure prompt efforts were made to resolve ongoing grievances regarding uncomfortable room temperatures for 2 of 2 residents (R31, R194) reviewed, who complained their shared room was too warm. Findings include: R31's admission Minimum Data Set (MDS), dated 4/3/18, identified R31 had moderate cognitive impairment, and had diagnoses including chronic obstructive pulmonary disease, pneumonia, and anxiety. R31's care plan, dated 4/13/18, included R31 was alert and oriented, and was capable of expressing needs/preferences/wishes. Also included, R31 used oxygen, had trouble falling asleep at night, was feeling tired and more restless than usual. R194's resident face sheet, dated 4/19/18, identified diagnoses including chronic kidney	21880	F285 Immediate Plan of Correction: . On 04/25/2018 Environmental Services Director replaced the thermostat in R 194's room. On 04/26/2018, resident R194 stated that her room was uncomfortable again. Maintenance employee went into resident room and replaced the valve control that was stuck. R194 has had no further concerns related to room temperature. Identification of other residents Facility staff have checked with all other residents to determine if there were any other concerns/grievances that had not been addressed. Any identified were promptly resolved. Measures put in place Facility staff were re-educated on the grievance process.	

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21880	Continued From page 21 disease, hypertension, and muscle weakness. R194's care plan, dated 4/23/18, identified R194 was alert and oriented, and capable of expressing needs/preferences/wishes. During an observation of medication administration with licensed practical nurse (LPN)-B on 4/25/18, at 8:15 a.m. R31 and R194 were in the room they shared, and complained their room was very warm. R31 stated the room is "expletive hot" and pointed to the thermostat on the wall. R31 stated she had told "who ever would listen" since her admission on 3/21/18 that the temperature in the room was uncomfortably warm, and the staff had turned down the thermostat. The thermostat was observed with recorded temperature of 81 degrees Fahrenheit, and R194 reported, although the thermostat had been "shut off" earlier in the day, the room remained "Unbearably hot." R194 stated they had been "telling everyone we can," and indicated she had talked to her occupational therapist on 4/22/18, whom said she would "tell someone." R31 complained that the room was so uncomfortably warm, she couldn't sleep at night and could hardly breathe at times. The baseboard heat on the window side of the room was warm to touch and warm air was felt blowing out of the vents. LPN-B stated maintenance staff performed daily checks on temperatures in the residents' rooms and stated, "Yes, maintenance is well aware" that R31 and R194's room was too warm. LPN-B made no attempt to contact maintenance staff about R31 and R194's complaints of the uncomfortable temperature in their room, and continued to pass medications. During an interview on 4/25/18, at 8:22 a.m. nursing assistant (NA)-D verified R31 and R194	21880	Monitoring mechanisms Audits will be completed of 10% of residents per week X 1 month and then monthly X 2 months by checking with the residents to see if any concerns/grievances have been resolved. Results of audits will be brought to QAPI committee for review. Person responsible: Administrator Date of completion: 6/1/18	

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21880	Continued From page 22 had verbalized several times that their room was too warm, and stated she had reported it verbally to the environmental supervisor (ES) "on the go," and had put in a request on the tablet at the nurse's station, "a couple weeks ago," to have the temperature issue looked at. NA-D stated she had also put a fan in the room. During an interview on 4/25/18, at 8:28 a.m. ES stated each resident room had an adjustable thermostat and the goal for minimum room temperature was 72 degrees. ES stated the warmth of the room was adjusted based on the resident's wishes. ES stated he was not aware of any complaints of rooms being too warm, especially on the west wing where R31 and R194 resided. Upon entering the room, ES stated, "My goodness, it is really hot in here." R31 stated, "I know, I live here." ES stated he would address the issue and stated, "I appreciate being told about this, I didn't know." During a follow up interview on 4/25/18, at 8:49 a.m. ES stated, "We tell nurses and nursing assistants that if something is up, to come to someone and let them know." ES stated he had not been told and had not gotten anything about the heat in R31 and R194's room and stated staff were supposed to put a request into the "maintenancecare.com" tablet at the nurse's station, which was transmitted directly to his phone. ES reviewed the maintenance requests for the past month, and none were regarding the uncomfortable temperature in R31 and R194's room. ES stated, "Those are pretty easy fixes. They can stick on or stick off. We just need to be told about it." ES stated he had taken care of the issue in R31 and R194's room in "five minutes," and would be keeping any eye on it to make sure it was taken care of.	21880		

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21880	Continued From page 23 When interviewed on 4/25/18, at 8:59 a.m. R194 stated, "The temperature feels so much better." R31 stated, "I can't believe how much better it is, and he fixed it so quickly." When interviewed on 4/26/18, at 3:07 p.m. the administrator indicated a grievance form was available for residents to file a grievance, but this issue should have been put into the maintenancecare.com system when R31 and R194 complained to staff of their discomfort in their room. The administrator stated, "This was never brought up," and indicated the process was not followed if floor staff were aware of the issue. The administrator stated, "They [staff] should have told someone." Review of the facility's policy, "Grievances: Registration and Disposition," revised 4/17, included, "Grievances can be filed orally or in writing and can be filed anonymously." Also included, "The staff person receiving the concern will initiate the Grievance form (106). Staff will assist residents to complete this form as needed." Further, "All grievances will be responded to within 7 days." Review of the facility's policy, "Facility Environment/Preventative Maintenance," revised 11/16, included, "Note: All employees will be encouraged and trained to report all needed repairs or unsanitary conditions immediately." SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents grievances are	21880		

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21880	Continued From page 24 addressed timely. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		