

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QPJR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00332

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245580		3. NAME AND ADDRESS OF FACILITY (L3) LAKEWOOD CARE CENTER (L4) 600 MAIN AVENUE SOUTH (L5) BAUDETTE, MN (L6) 56623		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	
2. STATE VENDOR OR MEDICAID NO. (L2) 911243000		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
6. DATE OF SURVEY 09/08/2014 (L34)		8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) 09/30	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10. THE FACILITY IS CERTIFIED AS: X A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size <u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A (L12)			
12. Total Facility Beds 36 (L18)		13. Total Certified Beds 36 (L17)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 36 (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 Lyla Burkman, Unit Supervisor		Date : 09/16/2014 (L19)		18. STATE SURVEY AGENCY APPROVAL Mark Meath Enforcement Specialist 11/07/2014 (L20)	

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

19. DETERMINATION OF ELIGIBILITY <input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 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 : <u> </u>	
22. ORIGINAL DATE OF PARTICIPATION 10/01/1991 (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 INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal OTHER 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28) (L31)		30. REMARKS Posted 11/10/2014 Co.	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE 09/11/2014 (L33)		DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245580

September 16, 2014

Mr. Jason Breuer, Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, Minnesota 56623

Dear Mr. Breuer:

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 August 7, 2014 the above facility is certified for:

36 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 36 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

A handwritten signature in black ink that reads "Mark Meath".

Mark Meath, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

General Information: (651) 201-5000 * TDD/TTY: (651) 201-5797 * Minnesota Relay Service: (800) 627-3529 *
www.health.state.mn.us

For directions to any of the MDH locations, call (651) 201-5000 * An Equal Opportunity Employer



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 16, 2014

Mr. Jason Breuer, Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, Minnesota 56623

RE: Project Number S5374023

Dear Mr. Breuer:

On July 28, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 23, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On September 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 23, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 7, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 23, 2014, effective August 7, 2014 and therefore remedies outlined in our letter to you dated July 28, 2014, will not be imposed.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

A handwritten signature in black ink that reads "Mark Meath".

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245580	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 9/8/2014
Name of Facility LAKEWOOD CARE CENTER		Street Address, City, State, Zip Code 600 MAIN AVENUE SOUTH BAUDETTE, MN 56623

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0456 Reg. # 483.70(c)(2) LSC _____	Correction Completed 08/07/2014	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____ LB/mm	Date: 09/16/2014	Signature of Surveyor: 28035	Date: 09/08/2014		
Reviewed By _____ CMS RO	Reviewed By _____	Date:	Signature of Surveyor:	Date:		
Followup to Survey Completed on: 7/23/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table border="0"> <tr> <td>YES</td> <td>NO</td> </tr> </table>			YES	NO
YES	NO					

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QPJR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00332

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245580		3. NAME AND ADDRESS OF FACILITY (L3) LAKEWOOD CARE CENTER (L4) 600 MAIN AVENUE SOUTH (L5) BAUDETTE, MN (L6) 56623		4. TYPE OF ACTION: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2. STATE VENDOR OR MEDICAID NO. (L2) 911243000		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
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12. Total Facility Beds 36 (L18)		13. Total Certified Beds 36 (L17)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 36 (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 :

Theresa Gullingsrud, HFE NEII

08/04/2014

(L19)

18. STATE SURVEY AGENCY APPROVAL

Date:

Mark Meath
Enforcement Specialist

09/08/2014

(L20)

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

19. DETERMINATION OF ELIGIBILITY

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 :

1. Facility is Eligible to Participate
2. Facility is not Eligible

(L21)

22. ORIGINAL DATE

23. LTC AGREEMENT

24. LTC AGREEMENT

26. TERMINATION ACTION:

(L30)

OF PARTICIPATION
10/01/1991

BEGINNING DATE

ENDING DATE

VOLUNTARY 00INVOLUNTARY

(L24)

(L41)

(L25)

01-Merger, Closure

05-Fail to Meet Health/Safety

02-Dissatisfaction W/ Reimbursement

06-Fail to Meet Agreement

03-Risk of Involuntary Termination

OTHER

04-Other Reason for Withdrawal

07-Provider Status Change

00-Active

25. LTC EXTENSION DATE:

27. ALTERNATIVE SANCTIONS

A. Suspension of Admissions:

(L44)

B. Rescind Suspension Date:

(L45)

(L27)

28. TERMINATION DATE:

29. INTERMEDIARY/CARRIER NO.

03001

(L28)

(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539

32. DETERMINATION OF APPROVAL DATE

(L32)

(L33)

DETERMINATION APPROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

July 28, 2014

Mr. Jason Breuer, Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, Minnesota 56623

RE: Project Number S5580025

Dear Mr. Breuer:

On July 23, 2014, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; 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), i.e., the plan of correction should be directed to:

**Lyla Burkman, Supervisor
Bemidji Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us**

Phone: (218) 308-2104

Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 1, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 1, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by October 23, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 23, 2015 (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.

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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

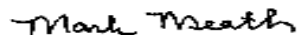
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118 Fax: (651) 215-9697

5580s14epoc

Lakewood Care Center

July 28, 2014

Page 6

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

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2014	
NAME OF PROVIDER OR SUPPLIER LAKEWOOD CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 600 MAIN AVENUE SOUTH BAUDETTE, MN 56623			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 4 kitchen refrigerators maintained appropriate temperatures for safe food storage, having the potential to affect 34 of 35 residents in the facility who received food items from these units. Findings include: On 7/23/14, at 7:20 a.m. the breakfast meal preparation was observed. Cook-A was observed to prepare the meals. Dietary aide (DA)-A was			F 456	F-456: Essential Equipment, Safe Operating Condition 1. The facility will address corrective action through the "Victory" refrigerator having been repaired by the maintenance staff and a certified cooling and air-conditioning professional as of 7/25/14. The Dietician has obtained quotes for a commercial refrigerator to replace the "Magic Chef" refrigerator. The commercial refrigerator will be installed and useable by August 25th, 2014. Until the new refrigerator can be obtained,		8/7/14

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

TITLE

(X6) DATE

Electronically Signed

08/04/2014

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.

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

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER LAKEWOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 MAIN AVENUE SOUTH BAUDETTE, MN 56623		
(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 456	<p>Continued From page 1</p> <p>observed to serve the meals along with a glass of milk to the residents in the dining room. DA-A was observed to obtain the milk from a small Magic Chef (dormitory size) refrigerator located on the counter next to the door to the dining room. The refrigerator was noted to be warm. A temperature log was not observed in the area of the refrigerator.</p> <p>At 7:30 a.m. the Victory refrigerator observed in the baker's area was noted to be warm. The thermometer indicated the refrigerator temperature was 58 degrees Fahrenheit (F). Cook-A was alerted to the warm refrigerator temperature. Cook-A was observed to remove a container of pancake mix in which she had placed in the refrigerator a few moments earlier. She then removed a tray with approximately 10 chicken salad sandwiches (mayonnaise based sandwiches) and directed DA-A to place the sandwiches in the walk in cooler. When questioned how long the refrigerator had not been working properly, Cook-A stated she did not know. Cook-A then directed DA-A to throw the chicken salad sandwiches into the garbage.</p> <p>At 9:13 a.m. the assistant to the registered dietitian entered the kitchen and confirmed per the thermometer, the Magic Chef refrigerator temperature was 47 degrees F. She then directed DA-A to throw the 5 half gallons of milk and 2 -1/2 gallons of almond milk away. The assistant stated staff were to check the temperature of the refrigerator daily, however, stated she had not established a monitoring sheet for the recording and monitoring of the refrigerator temperatures. The assistant then checked the Victory refrigerator and confirmed the temperature was 58 degrees F and stated it</p>	F 456	<p>beverages will be kept on ice bath, and temps of the fluids will be monitored and recorded at each meal service. These temps are monitored on a temperature log in the same manner as the refrigerators.</p> <p>2. The facility identified other refrigerators with the potential for being affected through temperature monitoring on a daily basis. No other refrigerators were found to be above acceptable temperature range since survey exit on 7/23/14.</p> <p>3. The facility measures in place to ensure that deficient practice will not recur involves the update to the policy and procedure "Grocery Storage and Issue" to instruct staff to notify Dietary Management during that shift if a temperature is elevated. Staff to continue to record temperatures daily. Education of proper refrigerator temperature will be reviewed at the monthly dietary staff meeting on August 7th, 2014. Review of the policy "Grocery Storage and Issue" will be documented via staff attendance record.</p> <p>4. The facility plans to monitor the performance of this plan and ensure solutions are sustained by assigning the Dietician or designee to review the temperature logs for all refrigerators four or more days per week through January 31st, 2015. The Dietician will monitor the refrigerator logs weekly through January 31st, 2015. The Dietician will review the temperature at that time to identify disparities. Data and findings will be reported to the QA/QI committee at each meeting beginning in September, 2014.</p>		

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

PRINTED: 08/05/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER LAKESWOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 MAIN AVENUE SOUTH BAUDETTE, MN 56623		
(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 456	<p>Continued From page 2</p> <p>was too warm. The assistant reviewed the Reach-in-Fridge Temperature Sheet for 7/2014. She reported the refrigerator temperature was 40-42 degrees F on four different occasions including on 7/22/14. She explained when the refrigerator temperature was too warm, staff were directed to recheck the temperature to ensure appropriate temperatures were maintained. She stated she was not aware the refrigerators were not functioning properly. She stated she would notify the maintenance department.</p> <p>The Grocery Storage and Issues policy reviewed on 4/2011, indicated the refrigerator temperatures were to be maintained at a range of 34-40 degrees F or below and directed staff to record the refrigeration units temperatures daily. The policy also indicated elevated temperatures were to be monitored and low temperatures were to be brought to the immediate attention of the Director of Dietary and/or Maintenance Personnel.</p>	F 456			

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

Printed: 07/25/2014
FORM APPROVED
OMB NO. 0938-0391

F5580223

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - NURSING HOME 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/23/2014
NAME OF PROVIDER OR SUPPLIER LAKEWOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 600 MAIN AVENUE SOUTH BAUDETTE, MN 56623		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>FIRE SAFETY</p> <p>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Lakewood Care Center 01 Main Building was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.</p> <p>Lakewood Care Center is a 1-story building without a basement and with a penthouse. The building was constructed in 2000, was determined to be of Type V (111) construction and is attached to the hospital building which is separated with a 2- hour fire barrier. The facility is divided into 3 smoke zones by 1- hour fire barriers.</p> <p>The building is fully sprinkler protected with a dry pipe sprinkler system installed in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The system is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The sleeping rooms have single smoke detectors and hazardous areas have automatic fire detection installed in accordance with the Minnesota State Fire Code (2007).</p> <p>The facility has a capacity of 40 beds and had a</p>	K 000			

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

TITLE

(X6) DATE

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

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

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K 000	Continued From page 1 census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
July 28, 2014

Mr. Jason Breuer, Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, Minnesota 56623

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5580025

Dear Mr. Breuer:

The above facility was surveyed on July 21, 2014 through July 23, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Lakewood Care Center

July 28, 2014

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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.

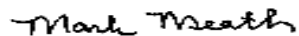
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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 Lyla Burkman at (218)308-2122 or email at: lyla.burkman@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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

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Lakewood Care Center

July 28, 2014

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Lakewood Care Center

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Page 4

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00332	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2014
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

LAKEWOOD CARE CENTER

**600 MAIN AVENUE SOUTH
BAUDETTE, MN 56623**

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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	2 000		

Minnesota Department of Health

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

TITLE

(X6) DATE

Electronically Signed

08/04/14

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00332	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/23/2014
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2 000	<p>Continued From page 1</p> <p>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.</p> <p>On 7/21/14, through 7/23/14, 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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	2 000		

Minnesota Department of Health

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2 000	Continued From page 2	2 000		
21426	<p>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.</p> <p>MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control</p> <p>(a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.</p> <p>(b) Written compliance with this subdivision must be maintained by the nursing home.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 1 licensed practical nurse (LPN)-A and 2 of 2 nursing assistants (NA-A, NA-B) received a tuberculosis (TB) symptom screening upon hire and a tuberculin skin testing (TST), with results documented. This had the potential to affect all 40 residents residing</p>	21426	<p>1. The facility will address corrective action through review of all staff members hired from 2/1/14 to 7/23/14. Those employees newly hired within the identified timeframe had employee health record review completed on 7/28/14. All staff that has not completed the 2 step mantoux</p>	8/15/14

Minnesota Department of Health

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21426	<p>Continued From page 3</p> <p>in the facility who received direct care by these employees.</p> <p>Findings include:</p> <p>LPN-A was hired 4/16/14, there was no documentation that TB screening or a TST had been done.</p> <p>NA-A was hired 2/88/14. There was no documentation TB symptom screening or a TST had been done.</p> <p>NA-B was hired 5/15/14. A TB screening was completed on 5/7/14, a first step TST done, but was not read with results documented. Another first step TST was done on 6/7/14, which was negative, a second step TST was done on 6/19/14, which was not read. Another first step TST was administered on 7/15/14, the second TST is pending.</p> <p>The facility policy titled Tuberculosis Screening for Employees, dated 2010, indicated: New employees who have been made a conditional offer of employment shall be screened for presence of infection with M. tuberculosis using the Mantoux TST. Skin testing will employ the two-step procedure. The Mantoux test should be read 48 to 72 hours after the injection.</p> <p>On 7/23/14, at 1:35 p.m. the director of nursing (DON) stated staff should have received their prescreening and TST and verified the facility policy was not followed and should have been.</p> <p>SUGGESTED METHOD OF CORRECTION:</p> <p>The DON could review and revise the TB policy and develop an auditing system to ensure all employees receive their TB symptom screening and tuberculin skin testing. The quality assurance and assessment committee could establish a system to audit tuberculosis testing to ensure compliance.</p>	21426	<p>process on hire has been contacted for PPD initiation. Several staff members were found to have completed the process, some in progress, some incomplete. One individual found to be incomplete as of 7/28/14 will be on LOA until October, 2014, will initiate PPD upon her return.</p> <p>2. The facility has identified other staff with the potential to be affected by auditing all staff employee health records for any missed PPD on hire. Audit complete 7/28/14.</p> <p>3. Ultimately, the facility Infection Control Nurse will continue to initiate and follow up on all new employee PPDs needed as per the facility policy. DON or designee will follow up on each new hire to obtain the dates of 1st and 2nd step PPDs to ensure completion. This follow up item has been added to the DON/ADON general orientation checklist used for all new employees. All new hires and PPD dates will be reported to the QA/QI committee at each meeting beginning September, 2014.</p>	

Minnesota Department of Health

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21426	Continued From page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		