Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 14, 2025

Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN 56623

RE: CCN: 245580
Cycle Start Date: September 11, 2024

Dear Administrator:

On September 17, 2024, we notified you a remedy was imposed. On January 9, 2025 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 8, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 2, 2024 be discontinued as of January 8, 2025. (42 CFR 488.417 (b))

In our letter of September 17, 2024, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 2, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 17, 2024

Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN 56623

RE: CCN: 245580
Cycle Start Date: September 11, 2024

Dear Administrator:

On September 11, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 2, 2024.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 2, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 2, 2024.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $12,924; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by October 2, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lakewood Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 2, 2024. You will receive further information regarding this from the State agency. 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.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

The purpose of the ePoC submission is to confirm your allegation of compliance and preparedness for a revisit.

Within ten (10) calendar days after your receipt of this notice, a provider should develop and submit an effective ePOC for the deficiencies cited. A revisit will determine if substantial compliance has been achieved.

A provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Regional Operations Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104

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 - Health Regulation Division 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

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

We will also recommend to the CMS location and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 11, 2025 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NHDisputeResolution

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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
E 000	Initial Comments On 9/9/24-9/11/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/9/24-9/11/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55807086C MN105726 with a deficiency cited at F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)	F 558		10/29/24

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

Electronically Signed | 09/25/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 558	Continued From page 1 §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a call light or device to alert staff was accessible for 1 of 1 residents (R21) observed to not have a way to call for staff assistance while sitting in their room. Findings include: R21's quarterly Minimum Data Set (MDS) dated 8/15/24, identified R21 was cognitively intact and required moderate to maximum assistance to transfer and had sustained a fall since his admission to the facility. R21's care plan dated 8/13/24, identified R21 was dependent on staff for meeting emotional, intellectual, physical and social needs related to physical limitations and cognitive deficits. R21 was also at risk for falls and had an actual fall without injury. The care plan outlined several interventions to maintain involvement and help reduce his risk of falls, which included to ensure that adaptive equipment was provided, present, and functional. On 9/9/24 at 12:42 p.m., R21 was observed sitting in a recliner in his room in a reclined position. No call light was observed near or in the recliner. A call light and reacher assistive device was observed lying across a round table in the	F 558	1. Regarding Resident R21 a room and environment assessment regarding reasonable accommodations or equipment has been completed. It was determined additional equipment modifications were needed for the resident call light accessibility. Additional appropriate equipment required ie: Call Light splitter, and extension, was received and placed into service for this resident. Completed by: 9/27/2024. 2. Regarding all other residents; All residents that have the same or similar identifiers will have a room and environment assessment regarding Call Light; to ensure reasonable accommodations or equipment access is attained. To be completed 10/4/2024. 3. To assure this deficient practice does not occur in the future for the facility; An Equipment/Needs Assessment (Specific to Call Light) has been added to the Admission Checklist so the Interdisciplinary Team can ensure the process is completed. The Call Light Response Policy has been updated effective 10/1/24. All Staff will receive education with the review of this policy by 10/11/24, or prior to their next shift scheduled after 10/11/24. Audits for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 558	Continued From page 2 corner of the room. The table was three to four feet away from R21's recliner and R21 was not able to reach any of the items on the table from where he was sitting. R21 stated he had a call light by his bed but did not have one within his reach when sitting in his recliner. He did not know what he would do if he needed to get staff assistance to the bathroom or if he needed something. R21 stated staff forgot to place the call light with in his reach quite often. On 9/10/24 at 4:36 p.m., nursing assistant (NA)-D was observed wheeling R21 to his room and transferred him to his recliner. NA-D turned on R21's television and provided him a snack on his bedside table next to the recliner. R21's call light and reacher device were observed to be on R21's round table three to four feet from the recliner. NA-D left the room without providing R21 with his call light or reacher device. During interview on 9/10/24 at 4:45 p.m., NA-A stated R21 was capable and did use his call light to call for staff assistance. All residents should have their call lights with in their reach when in their rooms. She would go in right away and give R21 his call light. When interviewed on 9/11/24 at 8:35 a.m., registered nurse (RN)-B stated R21 was able to use his call light and should have it with in his reach at all times. She would obtain a splitter for his call light cords so he could have one attached to his recliner to ensure he had one accessible at all times. During interview on 9/11/24 at 10:25 a.m., the director of nursing (DON) stated it was the expectation that all residents have their call lights	F 558	proper placement of a call light will be conducted to ensure staff are utilizing the tools (ie: Call light) for residents to call for help. Education on the new process is to be provided to admitting staff and IDT Team with planned completion by 10/4/2024. 4. To assure this practice enhancement is sustainable and hardwired, Leadership (IE: Director of Nursing, LTC RN Manager, an IDT team member or designee) shall complete audits as follows: DON will audit all Admissions for the completion of this Evaluation as they occur in the next 3 months. A Proper placement of a call light Audits will be conducted by leadership as follows: Audit 5 times a week starting 9/30/24 for 2 weeks. Audit weekly starting 10/14/24 for 2 weeks. Audit biweekly starting 10/28/24 for 2 months. Audit results will be reviewed Weekly at ITD: High Risk Meetings and at QAPI meetings for the next 6 months, ending 1/1/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 558	Continued From page 3 within their reach. The facility taught the staff to do deliberate rounding and at that time they were to check with the residents to see they have everything they needed, such as the call light and water. The facility policy Call Light Response dated 4/1/14, identified it was the facility policy to provide prompt responses to the requests and needs of the elders. When providing care to residents staff were to be sure to position the call light conveniently for the resident to use. The staff were to tell the resident where the call light was and how to use it. The staff were to be sure all call lights were placed within resident reach at all times and never on the floor or bedside stand.	F 558		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident,	F 583		10/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 583	Continued From page 4 including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(h)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to maintain confidentiality for 12 of 12 residents (R3, R4, R6, R8, R11, R14, R17, R19, R22, R24, R76, R77) whose personal health data was observed laying unattended in a public area visible to all who entered. Findings include: Team 1 (South) Memory Lane care sheet undated, identified personal care needs for all 12 residents residing on that wing. The information included: urinary intake/output, fasting blood sugars, bed/chair alarms, size and type of incontinent products, glasses, hearing aids, safety concerns, behaviors, and ability to perform Activities of Daily Living (ADL's). During an observation and interview on 9/10/24, at 8:46 a.m., nursing assistant (NA)-B was in the dining room requesting a meal for a R19. NA-B stated she had a care sheet that provided the care needs of all the residents on her assigned	F 583	1. Regarding Residents (R3, R4, R6, R8, R11, R14, R17, R19, R22, R24, R76, R77) During State Survey it was noted the understanding of maintaining confidentiality requirements were not met. An evaluation for security of resident information & handling was completed for the resident’s wings public areas. The staff member directly involved by the deficient practice will review the Resident Health Information / Confidentiality Policy and complete education on resident’s right to secure and confidential personal and medical records. 2. Regarding all other residents. An evaluation for security of resident information & handling was completed for all other public areas within the facility. 3. To assure this deficient practice does not occur in the future for the facility, A Resident Health Information / Confidentiality Policy has been Reviewed and Update (Or Created) Resident Health	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 583	Continued From page 5 wing, but NA-B had left it on the table "over there" pointing towards the hall. The care sheet was observed uncovered and left unattended on a tabletop in the public hallway. Staff, visitors, and residents were observed walking to and from the dining room for the breakfast meal, past the table and had the ability to view the information without obstruction. NA-B stated the care sheet was left on the table because she had been working at the facility for a while, and knew the residents' care needs so she would just mark residents off as she completed their cares. NA-B stated this was her normal routine. NA-B stated another resident, visitor or other staff could look at the care sheet and NA-B would not know unless she was at the table at the time. NA-B would not answer why it was important to keep resident personal information private. During an interview on 9/10/24 at 9:12 a.m., NA-C stated the care sheets should always be folded and in your pocket. If kept on the table, it should be in a place so it can be covered and where no one can see it. The care sheet should never be left out where others can see it because that's private information. If left on the table, anyone could pick it up and look at it. During an interview on 9/10/24 at 9:18 a.m., trained medication aide (TMA)-A stated the care sheet should never be left in a place where others can look at it because it was private resident information. During an interview on 9/10/24 at 9:32 a.m., TMA-B stated the nursing assistants were supposed to keep the care sheets on them so they can refer to them during cares. The care sheet should never be left at a table because	F 583	Information / Confidentiality Policy has been updated effective 10/1/24. All Staff will receive education with the review of the said policy and be educated on resident's right to secure and confidential personal and medical records completed by 10/11/24, or prior to their next shift scheduled after 10/11/24. Audits will be completed to assure and maintain compliance. Ensuring proper compliance is being completed as evidenced by no breach in confidentiality of resident information left unattended or without secure placement. 4. To assure this practice enhancement is sustainable and hardwired, Leadership (IE: Director(s) of Nursing, RN Manager, an IDT team member or designee) shall complete audits as follows: Audit of Proper placement of resident information will be completed as follows: Audit 5 times a week starting 9/30/24 for 2 weeks. Audit weekly starting 10/14/24 for 2 weeks. Audit biweekly starting 10/28/24 for 2 months. Audit results will be reviewed Weekly at ITD: High Risk Meetings and at QAPI meetings for the next 6 months, ending 1/1/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 583	Continued From page 6 other residents and/or family could pick it up and let that personal information out. During an interview on 9/10/24 at 11:02 a.m., registered nurse (RN)-C stated the nursing assistants should keep the care sheet in their pockets to refer to it during cares and to keep the resident information private. During an interview on 9/10/24 at 12:57 p.m., the director of nursing (DON) stated staff were expected to keep resident information private. During an interview on 9/10/24 at 2:06 p.m., the administrator stated staff were expected to keep resident information private. A facility policy regarding privacy was requested but not received.	F 583		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure fall interventions were implemented as care planned to prevent falls for 1 of 4 residents (R19) reviewed for falls. This resulted in actual harm to R19 who's fall resulted in a humerus (a long bone	F 689	1. Regarding Resident (R19) During State Survey with review of interview and records as well as observation it was determined requirements for fall prevention intervention implementation of care plan to prevent falls was not	10/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 689	Continued From page 7 in the arm that runs from the shoulder to the elbow) fracture. Findings include: R19's Therapy Eval and Re-Eval note dated 12/13/23 at 11:30 a.m., identified R19 was a high fall risk. R19 had difficulty following directions and was able to ambulate with contact guard assist (CGA) (a term used in physical therapy and occupational therapy to describe a level of assistance provided to a resident. Contact guard requires a hand on the resident (such as with a gait belt), "hover hands", "light hands", contact with the resident) and use of front-wheeled walker (FWW), but R19 chose to use a wheelchair for most mobility at that time. R19's Fall Risk assessment dated 6/23/24, identified R19 was at high risk for falls. R19's significant change Minimum Data Set (MDS) dated 8/15/24, identified R19 had severe cognitive impairment and diagnoses including Alzheimer's disease, dementia, and anxiety. R19 had impairment to one side of her upper body and required substantial/maximal assistance for Activities of Daily Living (ADL's). R19's Falls Care Area Assessment (CAA) dated 8/15/24, identified R19 was a fall risk due to a history of falls and dementia, and was unable to make safe/sound decisions. This area would be addressed in the care plan to slow or minimize decline, avoid complications, minimize risks, and to maintain current level of function. R19's care plan revised 8/16/24, identified R19 had an ADL self-care performance deficit related	F 689	followed. The staff member directly involved by the deficient practice was directed to reviewed and complete education regarding resident Care plan, Safety and Fall prevention implementation. (IE importance of following Care Plan). 2. Regarding all other residents. Review and update Care Plans regarding Fall Prevention to be completed by 10/4/24. 3. To assure this deficient practice does not occur in the future the Fall Prevention Policy was reviewed and updated effective 10/4/24. All Staff will receive education with the updates of the said policy and will be educated on the resident care plan, so their environment remains as free of accident hazards as is possible. Each resident will receive adequate assistive devices to prevent accidents. To be completed by 10/11/24, or prior to their next shift scheduled after 10/11/24. Audits will be conducted with staff to determine knowledge of fall prevention interventions put into place, in addition to ensuring residents adequate assistive devices are available to prevent accidents to provide a safe transferring and mobility environment to prevent falls. 4. To assure this practice enhancement is sustainable and hardwired, Leadership (IE:DON, LTC RN Manager, an IDT team member or designee) shall complete audits as follows: Audit of Proper placement of resident information will be completed as follows: Audit 5 times a week starting 9/30/24 for 2 weeks. Audit weekly starting 10/14/24 for 2	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 689	Continued From page 8 to Alzheimer's disease and dementia. R19 required a contact guard assist (CGA) with 2 staff and a gait belt to stand/pivot transfer. R19 was unsafe to walk, stand pivot transfers only with 2 person and a gait belt. However, the care plan lacked to identify if R19 could be left unattended at the bedside. The Team 1 (South) Memory Lane care sheet undated, identified R19 required extensive to total assist of 1-2 staff; floor bed, bed alarm with no chime and chair alarms; transfer with assist of 2, gait belt, stand and pivot; 1 hour safety rounding; turn slowly when in bed due to vertigo; gripper socks while in bed; brace on 24/7, skin checks twice a day, do not get wet, bed bath. The care sheet lacked to identify if R19 could be left unattended at the bedside. R19's Incident note dated 8/12/24 at 12:02 p.m., identified R19 had a fall that morning at 7:35 a.m. R19 was in her bathroom standing at the sink. NA went to grab R19's wheelchair just outside the bathroom door when the NA turned around R19 had fallen to the floor. R19 was on her right side, floor was dry, R19's shoes were on, the room had bright lighting, the room was quiet. R19 had just been toileted prior to the fall. R19 was lifted with a mechanical lift with 3 staff assisting. R19 was evaluated by nursing. R19 had a small skin tear to right side of forehead that was bleeding. When doing range of motion, R19 was unable to move right shoulder area. R19 was sent to emergency room (ER) for further evaluation. R9's Incident note dated 8/12/24 at 12:25 p.m., identified R19 returned from the ER around 10:30 a.m. R19 was to keep her right arm always immobilized with the use of a sling due to a	F 689	weeks. Audit biweekly starting 10/28/24 for 2 months. Audit results will be reviewed Weekly at ITD: High Risk Meetings and at QAPI meetings for the next 6 months, ending 1/1/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 689	Continued From page 9 fracture of the right humerus. R19'a CR/Shoulder 1V Rt dated 812/24, identified a non-displaced fracture of the right humerus. R19's Fall Risk Assessment dated 8/12/24, identified R19 was at high risk for falls. R19's High Risk Meeting note dated 8/13/24 at 12:57 p.m., identified R19's fall was discussed. R19's sling was to be left on continuously. Medications had been implemented for pain management. Physical (PT) and occupational (OT) therapy evaluation for transfers and recommendations was requested. Weekly weights to ensure no weight loss. Assist with meals as needed. R19 would have appointment with orthopedics. R19's Therapy Eval and Re-Eval note dated 8/14/24 at 1:45 p.m., identified R19 fell on 8/12/24 and sustained a right humerus fracture and an OT evaluation was ordered to determine best way to provide care for R19. R19 was in an immobilizer sling and pain was being managed with narcotic and muscle relaxer medications. R19 had an appointment scheduled with orthopedics on 8/15/24. OT rearranged the room which included moving the bed to the other side of the room, allowing staff access on either side of the bed and for R19 to enter/exit the bed leading with the left side. Gripper strips placed alongside the bed and in front of the toilet. R19 would need extensive to total assistance with ADL's at that time. Care needed to be taken with putting on the gait belt to keep it low and not bump her right arm. Move slowly, provide clear and simple instructions. Stand pivot transfers with 2-person assistance; no ambulation; use	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 689	Continued From page 10 wheelchair for functional mobility. R29 was fearful of falling and needed extra time and reassurance from staff. Care needed to be taken to keep right upper extremity relaxed (R19 tended to tighten this arm up which increases pain). New arrangement of room should help make access easier for staff and R19. The facility's 5-day report dated 8/16/24 at 2:49 p.m., identified staff did not follow the plan of care. The equipment needed to care for R19 was not accessible to NA-B when it was needed and NA-B did not retrieve the equipment prior to assisting R19. The corrective action plan was initiated including R19 evaluation by physician, PT/OT, Orthopedics; immobilize right arm with sling, change dressing routinely. Education to all staff regarding assistive devices, the need for all equipment to be available to the resident when needed. Care plan was updated for R19 and her dressing and transferring needs. An audit of all resident walkers to ensure that they were available and had their name on it. Interviewed cognitively intact residents that use gait belt for audit of gait belt use by staff. Creating a walk to dine policy. R19's weight will be monitored as well and her intakes to ensure R19 continues to eat and maintain her weight, weekly. However, the corrective action plan lacked to identify staff failure to provide contact guard assist for R19 nor education and/or audits that R19 was receiving contact guard assist to ensure her safety. During an observation on 9/10/24 at 8:13 a.m., the following was observed as nursing assistant (NA)-B provided morning cares to R19: - At 8:29 a.m., NA-B stated to R19, "alright, we're	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 689	Continued From page 11 going to sit up. I need to get you in your wheelchair and wash your back a little bit." NA-B lowered R19's bed to wheelchair height, however, left R19's wheelchair was at the foot of R19's bed. NA-B grasped R19 in a cradle lift and turned/lifted R19 to sit on the left side of R19's bed. NA-B stated to R19 "can you hold the rail and hold yourself up? I'm going to take my arm away." R19 was observed to grasp the bed siderail with her left hand tightly causing the knuckles of her left hand to blanch. - At 8:32 a.m., NA-B removed R19's shirt. NA-B turned her back on R19 while rinsing a washcloth in the basin of water. R19 balanced on the edge of R19's bed while holding on to the siderail. NA-B turned back to R19 and washed R19's underarms and back. - At 8:33 a.m., R19 stated she wanted to go to her own room. NA-B explained it was R19's room and took 3 steps away from R19 to obtain deodorant from R19's drawer. NA-B assisted R19 with her deodorant and putting on a sweater. - At 8:36 a.m., NA-B stated "we're going to hop in your wheelchair and go get breakfast. Sound like a plan? Hold the rail and I'm going to get the gait belt so I can get you in your wheelchair." NA-B took 5 steps away from R19 to the end of R19's bed, obtained the gait belt from R19's wheelchair and then placed R19 wheelchair next to R19. - At 8:37 a.m., NA-B placed a gait belt on R19 and stated "we're going to stand and pivot into the chair, ok?" NA-B stood R19 and pivoted R19 to her wheelchair. "There you go." During an interview on 9/10/24 at 8:46 a.m., NA-B stated R19 had fallen in her bathroom. R19 basically face-planted, fell and broke the top part of her right arm. Staff couldn't leave her alone in the bathroom. If staff needed something you had	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 689	Continued From page 12 to ask for it. Staff could not turn your back or walk away from her. NA-B stated staff did not have a way to ask for assistance other than turning the call light on. R19 was an assist of 1-2 depending on her day. Like today, R19's was doing really well and NA-B felt comfortable doing a pivot transfer. NA-B stated she did turn her back on R19 to rinse the washcloth and did step away from R19 to get deodorant, the gait belt, and to put the wheelchair in place for R19's transfer. NA-B then stated she did not carry a care sheet in her pocket because she had worked at the facility for a "while", knew the residents' care needed and just marked residents off as she completed tasks. Upon review of R19's care plan, NA-B stated she did transfer R19 with assist of 1 but did not know how to answer what R19's care plan directed. During an interview on 9/10/24 at 9:12 a.m., NA-C stated she was working the morning of 8/12/24 when R19 fell. R19 was at the bathroom sink and the nursing assistant that was with her stepped outside the bathroom to get the wheelchair. R19 fell and broke her arm. Staff were directed to do an assist of 2 stand and pivot for all transfers for R19. Staff assisted R19 with everything. "Staff cannot step away from R19. No. Nope. Never." Staff needed to look at the care sheets to make sure they know what care needs every resident required. That's what the care sheet was for. The care sheet should be always folded and in their pockets. During an interview on 9/10/24 at 9:18 a.m., trained medication aide (TMA)-A stated they talk about what resident needs/changes were in report before every shift, but staff needed to check the care sheet to make sure. R19 could not	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 689	Continued From page 13 be left out of reach at all and R19 needed an assist of 2 for all transfers as R19 was a high risk for falls. During an interview on 9/10/24 at 9:32 a.m., TMA-B stated she was working the other hallway the morning R19 fell. TMA-B didn't know a "whole lot" but knew R19's walker and gait belt had been left in the dining room the night before and weren't in her room. Normally, R19 walked to and from meals so the walker was left in the dining room from the night before. TMA-A stated she did not know if R19 was wearing a gait belt when she fell. TMA-B was never in the room and TMA-B was never informed if R19 was or wasn't wearing one. Prior to her fall, R19 could be very agile when she wanted to be. TMA-B stated she did not know if R19 ever had vertigo but R19 could be unsteady. Staff had to use a gait belt and have contact at all times to make sure R19 didn't fall. After R19's fall, staff were told to use the care plans, know what residents' needs were and to make sure all the devices to keep residents safe were available for use. Staff should never step away from R19. Right now, she's a stand and pivot with assist of 2 and a gait belt. Really, staff should only walk away from R19 if she's lying down with the bed to the floor with mats on each side or if she's with other staff. During an interview on 9/10/24 at 10:39 a.m., NA-A stated R19 used to be a fun, spunky lady before her fall. If R19 needed to use the bathroom, she could tell you. R19 was able to walk with a walker and a gait belt. R19 had vertigo and when R19 would get up she'd say she was dizzy. Staff had to stay by her, keep your hand on her, and tell her to take her time. Staff should never step away from R19. Now, R19 was	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 689	Continued From page 14 completely different and was terrified to fall again. R19 should always be an assist of 2 for that reason. During an interview on 9/10/24 at 10:49 a.m., NA-E stated she was assisting R19 the morning R19 fell. NA-E was getting R19 up to the bathroom and to get ready for the day. NA-E had assisted R19 to sit on the edge of the bed and NA-E was looking for R19's walker and gait belt. When NA-E had realized the walker and gait belt were not in R19's room, R19 had already started walking to the bathroom. R19 was known to just get up and walk. NA-E walked with R19 to the toilet and assisted R19 to sit down and changed R19's incontinent brief. NA-E did not turn on R19's call light to request someone find R19's walker and gait belt. NA-E assisted R19 to stand and walk to the sink to do oral cares. R19's wheelchair was outside R19's door. NA-E took "maybe" 3 steps away from R19 with NA-E's back was turned away from R19, "as I'm doing that, R19 lost her balance and fell onto the floor." NA-E stated, because NA-E was turned to the wheelchair, NA-E did not see R19 fall. R19 had been "really steady. She wasn't stumbling or losing her balance." R19 should have had a gait belt on her and a walker to walk and had never stood at the sink without a gait belt or walker before that day. Afterwards, NA-E had a meeting with registered nurse (RN)-C and the director of nursing (DON). NA-E was instructed to alway ensure R19 had the gait belt and walker before R19 started moving. NA-E stated she told RN-C and the DON, R19 was already moving and NA-E couldn't leave her. However, R19 had not been moving prior to NA-E sitting her up at the edge of the bed nor did NA-E request assistance once R19 was seated on the toilet. After R29 fell, NA-E	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 689	Continued From page 15 pushed the call light. However, R19 was bleeding from the cut above her eye and NA-E had to leave the room to the nurses's station to get assistance. R19 was now an assist of 2 for a stand pivot to get up out of bed. When I go into a room and start to help a resident, I need to make sure I have all the things I need before I start to make sure the resident is safe. NA-E stated R19 could not be left alone in the bathroom, however, did not know if R19 could sit on the edge of her bed without staff contact. During an interview on 9/10/24 at 11:02 a.m., RN-C stated R19 had lived at the facility approximately a year or so. R19 had fallen at a previous facility and was "pretty calm" the first few months of living at the facility. R19 became more active, but fluctuated. Previously, R19 could be sitting in the dining room with her walker and ambulate with a 1 person stand-by assist. Sometimes, R19 needed to self-propel in her wheelchair. Prior to R19's fall, R19 required extensive assist of 1 stand by assist. After R19's fall, interventions included bed and chair alarm, proper footwear, low bed with mats on the floor, not safe to walk, stand and pivot only with assist of 2 and a gait belt. RN-C stated it was hard to say if R19 could be left to sit on the edge of her bed and staff could turn away or walk away from R19 because RN-C would use her judgement in the moment to know if R19 appeared unsteady. "You have to turn and grab a towel. Things like that." RN-C stated she had not assessed R19 to determine if she was safe to sit on the edge of her bed without staff contact. Most of the time, nursing requested PT and OT to assess that for residents. RN-C stated staff were always expected to follow R19's care plan.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 689	Continued From page 16 During an interview on 9/10/24 at 12:57 p.m., the DON stated, prior to R19's fall, R19 required a contact guard assist of 1 person. R19 walked to and from the dining room for meals. Contact guard assist meant R19 could walk to dine with a walker, gait belt and staff made sure they had contact with the gait belt at all times. R19 would require the railing and staff assist of 1 for transfer but was able to do that fine. R19 was a little unsteady and would go way too fast, and take off down the hallway without you. R19 just didn't know how to reign that in to be at a safe pace and was impulsive. Regarding R19's fall, most importantly, we need to follow the care plan and it was care planned to use a gait belt. The walker should have been present as well and was part of the care plan. Staff were educated on the importance of using the care planned devices to keep residents safe. When R19 was standing at the sink, NA-E was to have a hand on the gait belt at all times to ensure R19 was safe. NA-B should have had a hand on R19 at all times and should have performed a stand pivot transfer with assist of 2 to ensure R19 was safe. During an interview on 9/10/24 at 1:18 p.m., the DON stated staff were provided education regarding regulatory expectations, the care plans and the care sheets, and assistive devices and gait belts were included. Staff signed off on attendance. The facility performed audits to ensure all assistive devices were accounted for and labeled with the resident's name. However, audits were not performed to ensure walkers were returned to the resident's room after meals, or to ensure staff were following the care plans. Additionally, a R19 did receive a PT/OT evaluation on how to transfer R19 safely but did not address safety such as the requirement of a	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 689	Continued From page 17 contact guard assist. During an interview on 9/10/24 at 1:34 p.m., the occupational therapist (OT)-A stated R19 was evaluated by OT and PT in August after R19's fall because R19 was fearful of falling. That's what R19 needed at that time, reassurance. The OT stated R19 was not evaluated for contact guard assist while seated at the edge of the bed, but contact guard assist should continue to be used until evaluated. R19's OT Evaluation LCC 24-5580 dated 9/11/24 at 10:23 a.m., identified NA completed lower body dressing while R19 was still supine in bed. NA then assisted R19 to side of bed. R19 held her body stiff with posterior lean while she sat on the edge of the bed. OT stayed beside her and explained task of putting gait belt on while NA completed task. This helped keep R19 calm and then OT did stand pivot from bed to wheelchair with moderate assistance. R19 still demonstrated a posterior lean and needed cueing and time to move her feet with pivoting. Once seated in the wheelchair, NA was able to complete grooming tasks with R19. NA and OT were able to position R19 in wheelchair for better comfort. Assessment: R19 needed time and simple explanation of tasks while staff were working with her. R19 did express fear with movement so staff needed to be attentive and reassuring during functional mobility. R19 needed 2-person assistance for safety with stand pivot transfers. Tasks such as grooming could be completed with 1 staff if R19 was sitting in the wheelchair. All other tasks that involved moving from a supine to sitting to standing position should be completed with 2 staff.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 689	Continued From page 18 During an interview on 9/10/24 at 2:06 p.m., administrator stated staff were expected to follow the care plan to ensure resident safety. The facility policy Falls Prevention revised 8/7/24, identified it was the intent of the facility to ensure the provision and environment that was free from hazards over which the organization had control and provides the appropriate supervision to each resident to prevent avoidable accidents. This includes systems and processes designed to: - Identify hazards and risks. - Evaluate and analyze hazards and risks. - Implement interventions to reduce hazards and risks. - Monitor for effectiveness and modify approaches as indicated. - Residents receive supervision and assistive devices to prevent avoidable accidents. Implementation of Falls Management: 1. Each fall will be followed by the High-Risk Committee per the committee guidelines on a weekly basis until interventions are deemed appropriate. See High Risk Committee guidelines for more info. 2. Identification of residents in the facility that the committee evaluates to focus on fall reduction includes: those who have experienced injury from a fall within the last 3 months, those who have had one or more falls in the last 30 days, those who have a physical restraint, those who are newly admitted to the facility, are at risk for future falls due to the aging process, disease process, physiological factors or medications, those who are at risk for incidents related to environment, elopement issues or behavioral issues. 3. A fall risk assessment is used to assess all residents at the time of admission, readmission, identification of a significant change in status, and	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 689	Continued From page 19 then on a quarterly basis thereafter to continuously assess for fall potential. 4. An inventory of interventions or approaches is used for preventing falls. The interventions are documented, and effectiveness is evaluated, care plans updated, and communicated to staff responsible for implementation. 5. Staff is provided with in-service training on a regular basis to include training on new safety devices or equipment recommended and implemented. Staff is trained to recognize and eliminate environmental hazards and how to provide adequate supervision to prevent falls. 6. The effectiveness of selected interventions is evaluated by IDT team during the High-Risk Committee meeting to analyze patterns of falls within the facility. This is done through an incident reporting system (IRIS).	F 689		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and	F 812		10/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 812	Continued From page 20 serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure unpasteurized shelled eggs were fully cooked and prepared in a manner to prevent foodborne illness. This had the potential affect 5 of 5 residents (R4, R10, R13, R20, and R21) who regularly ordered undercooked eggs for breakfast, with the potential to affect all 24 residents. Finding include: R4's quarterly Minimum Data Set (MDS) dated 7/18/24, identified no cognitive impairment and had a diagnosis of diabetes. R10's quarterly MDS dated 6/28/24, identified no cognitive impairment and had a diagnosis of Parkinson's disease. R13's quarterly MDS dated 7/11/24, identified severe cognitive impairment. R20's quarterly MDS dated 7/25/24, identified no cognitive impairment and had a diagnosis of cancer of prostate. R21's quarterly MDS dated 8/15/24, identified no cognitive impairment and had a diagnosis of chronic kidney disease and autoimmune thyroiditis. During observations and interview on the initial kitchen tour on 9/9/24 at 12:15 p.m., the cook's refrigerator had 7 flats of eggs (one flat contained 30 eggs). The flats, as well as the box which the	F 812	1. Regarding Residents (R4, R10, R13, R20, R21) During State Survey it was brought to attention Unpasteurized eggs were being ordered and prepared undercooked (with runny yolks), and the eggs should be pasteurized if being served in this manor. Ordering process was evaluated and corrected to order pasteurized eggs only. 2. Regarding all other residents: the ordering process has been evaluated and corrected to order pasteurized eggs only. 3. To assure this deficient practice does not occur in the future for the facility, the Purchasing for the Nutrition Services Policy has been created. All Staff involved in the ordering process will receive education with the review of the said policy and process to ensure ordering Unpasteurized eggs is avoided in the future. Education completed 9/27/24. 4. To assure this practice enhancement is sustainable and hardwired, Leadership (Kitchen Manager, Dietary Lead, or an IDT team member designee) shall complete audits as follows: Ordering audits will be conducted by leadership as follows: Audit 2 times a week starting 9/30/24 for 2 weeks. Audit weekly starting 10/14/24 for 2 weeks. Audit biweekly starting 10/28/24 for 2 months. Audit results will be reviewed Weekly at	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 812	Continued From page 21 flats came in, did not indicate the eggs were pasteurized. Cook (C-A) looked at the eggs and the box they came in and stated there was no indication they were pasteurized. C-A would assume the eggs were pasteurized, because residents would order eggs over-easy (prepared undercooked with runny yolks), and the eggs should be pasteurized if being served that way. During observation on 9/10/24 at 7:27 a.m., C-A started to make breakfast for R13 which included 2 over-easy eggs from the eggs in the cook's refrigerator. The same eggs from the day before. The eggs were removed from the griddle at 7:29 a.m. and plated with bacon and toast. At 7:35 a.m. the dietary aide picked up the plate for R13 and started to walk to the dining room to give the plate to R13. The surveyor stopped the dietary aide from delivering the over-easy eggs and checked with C-A who stated it was not verified if the eggs were pasteurized. C-A remade R13 eggs and were cooked until firm. During observation on 9/10/24 at 7:46 a.m., R4 had come to the kitchen door and requested 2 over-easy eggs. R4 received scrambled eggs instead. During observation in the dining room R10 was heard saying she was going to order over-easy eggs because she likes to dip the toast in it. R10 did not receive over-easy eggs. During and interview on 9/10/24 @ 8:15 a.m., the social worker (SW) stated they assisted with the ordering and had been ordering the same eggs for the past 6 months. SW was unsure if the eggs which had been ordered were pasteurized or not. The SW opened the food distributors web site	F 812	ITD: High Risk Meetings and at QAPI meetings for the next 6 months, ending 1/1/2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 812	Continued From page 22 and identified the type of eggs that had been ordered and stated they did not say if they were pasteurized. The description of the eggs identified "To prevent illness from bacteria cook eggs until yolks are firm." They had not ordered the eggs that were identified as pasteurized and this could make the residents ill. During an interview on 9/10/24 at 2:36 p.m., R21 stated they like breakfast in the morning and will usually get eggs over-easy. R21 had not had any gastrointestinal (GI) issues when he ate eggs. During an interview on 9/10/24 @ 2:41 p.m., R20 stated they like their eggs prepared either over-easy or over-medium. Likes the yolks to be runny. R20 had not complained of any GI issues from eating eggs. During an interview on 9/10/24 at 2:45 p.m., R4 stated they like to order eggs over-easy with sausage. R4 had not complained of any GI issues from eating eggs. During a phone interview on 9/10/24 at 2:26 p.m., the dietician stated it is the expectation the facility would use pasteurized eggs when breakfast was prepared for the residents. Using unpasteurized eggs for under cooked or runny eggs could cause serious infection, illness and could lead to death. During an interview on 9/10/24 at 2:49 p.m., the administrator stated the expectation was to ensure food was prepared safely for the residents and would expect pasteurized eggs be used to ensure resident safety. The United States Department of Agriculture (USDA)-Food Safety and Inspection Service	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 812	Continued From page 23 article "Shell Eggs from Farm to Table" dated 11/4/19, identified it is possible for shell eggs to be infected with salmonella enteritis (a bacterial disease that can cause GI illness in humans and can have severe consequences in highly vulnerable people, like the young, old, and immunocompromised). To prevent illness from bacteria, cook eggs until the yolks are firm. A policy regarding ordering food and food safety was requested, but none were received.	F 812		
F 881 SS=D	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement antibiotic stewardship protocols for 1 of 1 resident (R7) identified to have been taking an antibiotic. Findings include: R7's quarterly Minimum Data Set (MDS) dated 7/25/24, identified severe cognitive impairment. Diagnoses included dementia, urinary tract infections, unspecified psychosis, and encounter for palliative care.	F 881	1.How corrective action will be accomplished for those residents found to have been affected by the deficient practice. R7 was unharmed from deficient practice and is no longer receiving daily antibiotics. Immediate education was provided to R7s RN on UTI protocol; assessing resident and implementing UTI tracking form should have been completed prior to reaching out to physcian. Antibiotic Stewardship Meeting will be held with Administrator, Medical Director,	10/29/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 881	Continued From page 24 R7's care plan revised 4/9/24, identified R7 was incontinent of bowel and bladder and was totally dependent with eating and toileting. Staff were directed to provide assistance with meals and snacks and check and change for incontinence every two hours. R7's progress notes identified the following: -On 6/26/24, urinalysis (UA) sample was obtained via straight catheterization and delivered to the lab. -On 6/27/24, discussed with family regarding underlying potential urinary tract infections (UTI) due to continual incontinence, requesting maintenance dose of an antibiotic for prophylactic use. Education was given regarding antibiotic stewardship and use of antibiotics was discussed and family still preferred nursing to contact provider and request a low dose of antibiotic. Chart audit indicated UTI treatments two to three times over the past couple of years. Obtaining a current UA for baseline resulted in a positive UTI and order of a course of treatment followed by an maintenance dose for UTI prevention. Probiotics were also incorporated. Family was updated. -On 7/2/24, antibiotic time out. Culture was received and showed resistance to ciprofloxacin. The provider was contacted and an order to discontinue ciprofloxacin and give Rocephin 1 gram intramuscularly (IM). One time only was received. -On 7/9/24, the family requested a repeat UA or other intervention due to R7 having had a UTI on 6/26/24. Family reported R7 was still not eating quite right. Primary physician was notified and an order was received for Rocephin 1 gram IM for five days for symptoms of UTI. R7's progress notes were reviewed 6/11/24	F 881	Pharmacist, Director of Nursing, Infection Preventionist to review ASP policy and procedures, Loeb and McGeer criteria and updated processes for the initiation of abx as well as the monitoring and doucumentation of suspected/current infections.(9/30/2024) UTI Policy updated Further discussion with Senior Leadership and Lab Director on possible ideas on how the facility can obtain microbiology cultures in a more timely manner. 2.How the facility will identify other residents having the potential to be affected by the same deficient practice. All facility residents have the potential to be affected by the deficient practice. Antibiotic Stewardship in-service will be held for all clinical staff (10/03/24) Education will be provided to current/future residents and/or their POAs. They will receive a copy of, “Do You Need Antibiotics? Information About Antibiotics for Nursing Home Residents and Their Families” with a copy of our Antibiotic Stewardship policy and procedure. The Infection Preventionist will track all infections; infection control logs, lab/diagnostic results, organisms, names of prescribing physicians, antibiotic therapies and whether or not follow-up communication has occurred with physicians. Infection Preventionist will provide educational support to long term care staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 881	Continued From page 25 through 7/11/24. The medical record lacked evidence of any assessment of signs and/or symptoms of infection. Further, there was no evidence of obtaining a UA and/or culture prior to initiating antibiotic treatment on 7/9/24. During interview on 9/10/24 at 1:21 p.m., registered nurse (RN)-A stated R7 had a positive UA on 6/26/24, and so ciprofloxacin had been initiated, then the culture came back the following week and indicated resistive to ciprofloxacin. The physician then ordered one dose of Rocephin. The real problem was that it took so long to get the culture back, which was an ongoing problem for the facility. She had discussed with the pharmacist possible solutions and they had thought to try to hold the antibiotic until culture results were received and push water, cranberry juice, and other interventions until they received culture results. Starting residents on antibiotics before reviewing the culture results could result in not properly treating and they were inviting a risk for Clostridium difficile colitis (a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon) and can be life-threatening). RN-A felt there should have been an assessment and/or non-pharmacological intervention for symptoms and education to the family prior to calling the physician for a second course of antibiotic treatment. The facility was working on trying to get some kind of protocols or assessment in place for staff to use when signs or symptoms of infection were suspected. When interviewed on 9/11/24 at 9:40 a.m., RN-B stated the family felt R7's decreased appetite was a symptom of still having a UTI and they wanted us to do more, so they had contacted the physician and he ordered the Rocephin for five	F 881	and resident families if questions or concerns arise with Antibiotic Stewardship Program. 3.What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur. The following measures will be implemented to ensure compliance: Protocol development for suspected infections. Licensed nursing staff will be educated on their roles and responsibilities for antibiotic stewardship and suspected/current infection protocols, including assessments and documentation.(10/03/24) Daily monitoring of clinical dashboard by IP and Pharmacist to ensure all necessary information is present notation of onset and description of the symptoms that require a change in the care plan/medical treatment, supporting documentation for use of antibiotics, appropriate antibiotic/dosage related to identified infection and pharmacy review. Any antibiotics ordered inappropriately will be discussed with the prescriber and documented. Facility will activate the PointClickCare Infection Control Dashboard to aid in surveillance, management, and reporting of infection cases.(TBD) Educational Binder developed for nursing staff containing the following Completed example of PCC eINTERACT Change in Condition Evaluation. INTERACT Guidance on Identification	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 881	Continued From page 26 days. She did not know why a patient assessment or interventions such as increased fluids had not been implemented first. The facility's normal procedure was to start a three day UTI tracking form and push fluids. Then they reviewed that and determined if a urinalysis was needed. After reviewing the progress notes for R7, RN-B stated she would have done a three day UTI tracking form or at least spoken with staff to see if they were seeing any symptoms or issues with R7 prior to contacting the physician for a second course of antibiotic treatment. The facility was working on improving their documentation regarding signs and symptoms of infection and the use of antibiotics. During interview on 9/11/24 at 10:09 a.m., the director of nursing (DON) stated they had just been discussing the infection control program and things they could do for documenting in the medical record, such as what staff were seeing for symptoms of infection. There was a lag in their system that the facility did not get their cultures back in a timely manner. That was a big handicap for the facility. The expectation was that the staff would need to assess the signs and symptoms and determine what nurse was assessing. They do use a UTI tracking form and then the nurses do an evaluation of those findings. Looking for things such as fever, lethargy, a decrease in urine output, or foul urine. It would have been more appropriate for staff to have put R7 on a UTI tracking form and monitor for symptoms of infection prior to contacting the physician for antibiotic treatment. Facility Infection Control policy dated 6/24, identified the facility's antibiotic stewardship program aimed to optimize the treatment of	F 881	and Management of Infections CARE PATH algorithms on illnesses Change in Condition Guide: When to report to the MD/NP/PA/RN. 4.How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. The Director of Nursing along with the Infection Preventionist and/or other designee will audit compliance of antibiotic stewardship program, e.g. evaluation of resident health concern, documentation, interventions, abx criteria/diagnostics tests daily X4 weeks then 3X/wk for 4 weeks then 1X/wk for 4 weeks. Audits will be reviewed quarterly or as needed by IDT and QAPI commitee to ensure ongoing commitment and compliance to antibiotic stewardship program.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 09/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	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 881	Continued From page 27 infections and reduce adverse events associated with antibiotic use. Objectives included to promote a culture of optimal antibiotic use and ensure timely and appropriate initiation of antibiotics. Actions and interventions included the development of antimicrobial related policies, appropriate use guidelines, microbiology lab susceptibility reporting and evidence based care paths and order sets for infectious diseases and active targeted interventions to guide, monitor and encourage appropriate use. The facility's Urinary Tract Infection policy revised date 12/17, identified procedures for staff to use which included to identify residents with probable urinary tract infections. Signs and symptoms would include urinary frequency, pain on urination, confusion, loss of appetite, back pain, low grade temperature, vomiting, nausea, decline in functional status, increased pain, anxiety and possible elevated blood sugar. Staff were to initiate a UTI tracking form for three days to identify the presence of three symptoms of UTI. Along with monitoring, staff were to push fluids and supplement or offer cranberry juice to decrease symptoms related to decreased fluid intake. If there were not three symptoms identified, the registered nurse would evaluate and follow up with provider if needed. If three symptoms were identified the provider could be contacted immediately.	F 881		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**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	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/10/2024. At the time of this survey, Lakewood Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 09/26/2024

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**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	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

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.

The facility has a capacity of 32 beds and had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**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	Continued From page 2 census of 26 at the time of the survey. The requirements at 42 CFR, Subpart 483.70(a), are NOT MET as evidenced by	K 000		
K 226 SS=F	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain stairwell arrangement and markings per NFPA 101 (2012 edition), Life Safety Code, section 19.2.2.5, 19.2.2.5.1 through 19.2.2.5.4, 7.2.4, 7.2.4.3.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/10/2024, between 0730am and 1130am, it was revealed by observation that the door in the fire barrior wall creating a horizontal exit from one smoke compartment to another was not a rated door as required by NFPA 101 (2012 edition), chapter 7. This door was located in the Service Entry hallway behind the kitchen area. An interview with Director of Environmental	K 226	K226 Description of Corrective action taken: Facility Director reached out to Door Vendors to replace the existing Door with a fire rated door, swap the Dietary-Fire Rated Door located in the facility or another vendor to investigate and possibly check the door for a recertification fire rating. Closer inspection did verify the metal frame supporting the door is fire rated. Both vendors agreed to inspect and a decision will be made as which route to take K226 Address the measures that will be put in place to ensure the deficiency does not reoccur: Replace the Door or verify the door in place can be fire rated K226 Indicate how the facility plans to monitor future performance to ensure solutions are sustained: Add Door to be replaced to Fire and Smoke Door	11/26/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**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 226	Continued From page 3 Services verified these deficient findings at the time of discovery.	K 226	Inspection sheet, Inspect, all doors within a fire rated compartment semi- annually per NFPA 80 K226 Identify who is responsible for the corrective actions and monitoring compliance: Chris Bowman Facility Manager/Lakewood Health K226 The Actual or Proposed Date of the remedy: It was confirmed by Vendor that a Replacement could be installed November 26th 2024 with a 4-5 week lead time on new door. It could be less if the door gets recertified. Chris Bowman Facility Manager will reach out to Fire Marshal if the second plan of recertification comes into effect.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A	K 321		9/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**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 321	Continued From page 4 a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous rooms per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1.2, 19.3.2.1.3, 8.4.3.5, 8.3.3.1, and 7.2.1.8.1. These deficient findings could have a isolated impact on the residents within the facility. Findings include: On 09/10/2024, between 0730am and 1130am, it was revealed by observation that door to the kitchen was propped open. An interview with Director of Environmental Services verified these deficient findings at the time of discovery.	K 321	K321 Description of Corrective action taken: Facility Manager Chris Bowman met with Dietary Director Chris Pieper and the Dietary Supervisor Julie Mollberg and discussed the incident and also plan to correct. The Managers including Chris Bowman will meet with Dietary Staff to review the Policy. Signage will also be used to reinforce this so it doesn't happen in the future. K321 Address the measures that will be put in place to ensure the deficiency does not reoccur: Signage will be used to reinforce this so it doesn't happen in the future. K321 Indicate how the facility plans to monitor future performance to ensure solutions are sustained: Environment of Care Safety Rounding will also include an employee or Manager of the Dietary department to further ensure that doors in the area are not propped open. K321 Identify who is responsible for the corrective actions and monitoring compliance: The persons responsible will be Chris Bowman Facility Manager, Chris	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**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 321	Continued From page 5	K 321	Pieper Dietary Director, Julie Mollberg Dietary Manager. K321 The Actual or Proposed Date of the remedy: The date for Completion 9/23/2024	
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 a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, 4.7.4, and 4.6.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 09/10/2024, between 0730am and 1130am, it was revealed by a review of available documentation that third shift fire drills did not meet the varying time requirement. An interview with Director of Environmental Services verified these deficient findings at the time of discovery.	K 712	K712 Description of Corrective action taken: Facility Manager met with Maintenance staff, the staff responsible for the fire drills, Nick Retka, Joe Borg and Brandon Hill to discuss tag K712 and review future actions of scheduling a night shift fire drill and ensuring it doesn't happen again. K712 Address the measures that will be put in place to ensure the deficiency does not reoccur: 1. All previous drills will be reviewed by Maintenance staff at the beginning of each month when the fire drill is scheduled. K712 Indicate how the facility plans to monitor future performance to ensure solutions are sustained: Monthly reviews of all fire drills and times will be gone over by	9/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**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 712	Continued From page 6	K 712	Chris Bowman, Nick Retka, Brandon Hill, Joe Borg K712 Identify who is responsible for the corrective actions and monitoring compliance Chris Bowman Facility Manager will be responsible for the corrective actions and Monitoring Compliance. K712 The Actual or Proposed Date of the remedy The date for completion 9/23/2024	
K 753 SS=D	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation or a review of available documentation and staff interview, the facility failed to prohibit combustible decorations per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.5.6 and 19.7.5.6 (4). These deficient findings could have an isolated impact on the residents within the	K 753	K753 Description of Corrective action taken: Facility Manager Discussed with Department Leaders Roxanne Larson Nursing Home Director, Chris Pieper Social Services, Josiah Hoagland Mission Services Tag 753. To correct the	9/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING **01 - NURSING HOME 01** B. WING _____	**09/10/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**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 753	Continued From page 7 facility. Findings include: On 09/10/2024, between 0730am and 1130am, it was revealed by observation that two (2) candles was located on a wooden shelf in the chapel. These candles must have the wicks removed or the candles must be secured when not in use. An interview with Director of Environmental Services verified these deficient findings at the time of discovery	K 753	deficiency, all member agreed to remove the candles from Lakewood Health K753 Address the measures that will be put in place to ensure the deficiency does not reoccur: Candles will be replaced with electronic candles K753 Identify who is responsible for the corrective actions and monitoring compliance Chris Bowman Facility Director, Josiah Hoagland Mission Director, Roxanne Larson Nursing Home Director K753 The Actual or Proposed Date of the remedy: The date for completion Completion 9/23/2024	