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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: SUH6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00451

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/27/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **46** (L18)

13.Total Certified Beds **46** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Kathie Killoran, HFE NEII — 06/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Enforcement Specialist — 06/10/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/19/2015
(L33)

Posted 06/10/2015 Co.

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24 5374

On May 27, 2015, the Minnesota Department of Health completed a Post Certification Revisit to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on April 8, 2015. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of May 18, 2015. We have determined, based on our visit, that the facility has corrected the deficiencies issued pursuant to our extended survey, completed on April 8, 2015, as of May 18, 2015.

As a result of the revisit findings, the Department discontined the Category 1 remedy of state monitoring effective May 18, 2015

In accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), a facility is
prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs when an extended survey identifies substandard quality of care was provided. Thus, Lakeside Medical Center is prohibited from conducting NATCEP for two years from July 8, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of April 28, 2015:

- Federal Civil Money Penalty of $5,800.00 per day for the six (6) days beginning April 2, 2015 and continuing through April 7, 2015 for a total of $34,800.00, remain in effect. (42 CFR 488.430 through 488.444)

- Federal Civil Money Penalty of $300.00 per day beginning April 8, 2015, be discontinued as of May 18, 2015. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 8, 2015, be rescinded. (42 CFR 488.417 (b))

Refer to the CMS 2567b form for health.

Effective May 18, 2015, the facility is certified for 46 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245374

June 10, 2015

Mr. Scott Kallstrom, Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, Minnesota 55063

Dear Mr. Kallstrom:

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

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

Effective May 18, 2015 the above facility is certified for:

46 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 10, 2015

Mr. Scott Kallstrom, Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, Minnesota 55063

RE: Project Number S5374024

Dear Mr. Kallstrom:

On April 23, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 28, 2015. (42 CFR 488.422)

On April 28, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Federal Civil Money Penalty of $5,800.00 per day for the six (6) days beginning April 2, 2015 and continuing through April 7, 2015 for a total of $34,800.00. (42 CFR 488.430 through 488.444)

- Federal Civil Money Penalty of $300.00 per day beginning April 8, 2015. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 8, 2015. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on April 8, 2015. The most serious deficiency was found to be widespread deficiencies that constituted immediate jeopardy (Level L), whereby corrections were required.

On May 28, 2015, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on April 8, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 18, 2015. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on April 8, 2015, as of May 18, 2015.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 18, 2015.

However, as we notified you in our letter of April 23, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 8, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of April 28, 2015:

- Federal Civil Money Penalty of $5,800.00 per day for the six (6) days beginning April 2, 2015 and continuing through April 7, 2015 for a total of $34,800.00, remain in effect. (42 CFR 488.430 through 488.444)

- Federal Civil Money Penalty of $300.00 per day beginning April 8, 2015, be discontinued as of May 18, 2015. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 8, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245374	A. Building B. Wing	5/27/2015

Name of Facility	Street Address, City, State, Zip Code
LAKESIDE MEDICAL CENTER	129 EAST 6TH AVENUE PINE CITY, MN 55063

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0151** Reg. # **483.10(a)(1)&(2)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0153** Reg. # **483.10(b)(2)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **05/18/2015**
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0205** Reg. # **483.12(b)(1)&(2)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **05/18/2015**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **05/18/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	Correction Completed **05/18/2015**
ID Prefix **F0367** Reg. # **483.35(e)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/18/2015**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CC/mm	06/10/2015	29625	05/28/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245374	A. Building B. Wing	5/27/2015

Name of Facility	Street Address, City, State, Zip Code
LAKESIDE MEDICAL CENTER	129 EAST 6TH AVENUE PINE CITY, MN 55063

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0469** Reg. # **483.70(h)(4)** LSC	Correction Completed **05/18/2015**	ID Prefix **F0490** Reg. # **483.75** LSC	Correction Completed **05/18/2015**	ID Prefix **F0501** Reg. # **483.75(i)** LSC	Correction Completed **05/18/2015**
ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **05/18/2015**				

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	CC/mm	06/10/2015	29625	05/28/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/8/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: SUH6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00451

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/08/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **46** (L18)

13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kimberly Settergren, HFE NEII 05/11/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 05/19/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 05/19/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5374

On April 8, 2015, an extended survey was completed at your facility by the Minnesota Department 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.

The facility was not in substantial compliance with the participation requirements and the conditions in the facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in the facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. ther facility meets this criterion. Therefore, the Department is imposing the following remedy:

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F151. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F226. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F244. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F333. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F425. (42 CFR 488.430 through 488.444)

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Lakeside Medical Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 8, 2015.

Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 23, 2015

Mr. Max Blaufuss, Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, Minnesota 55063

RE: Project Number S5374024

Dear Mr. Blaufuss:

On April 8, 2015, an extended survey was completed at your facility by the Minnesota Department 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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

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

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not

immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on April 8, 2015, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: chris.campbell@state.mn.us

Phone: (218) 302-6151
Fax: (218) 723-2359

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore,

the Department is imposing the following remedy:

• State Monitoring effective April 28, 2015. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F151. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F226. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F244. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F333. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F425. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Lakeside Medical Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective April 8, 2015. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 8, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 8, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

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

cc: Licensing and Certification File

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	04/08/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A survey was conducted by the Minnesota Department of Health on March 30, 31, April 1, 2, 3, 4, 5, 6, 7, and 8, 2015. An extended survey was conducted on April 2, 3, 4, 5, 6, 7, and 8, 2015. The survey resulted in an Immediate Jeopardy (IJ) at F333 related to the facility's significant medication errors for R36 who received a narcotic overdose resulting in a decline in condition, and R49, R39 and R58 who received wrong medications. Additionally the Immediate Jeopardy was identified at F425 for pharmacy services due to systemic problem with medication errors without analysis or assessment of cause for the errors. The IJs had the potential to effect 31 of 31 residents in the facility due to system failure. The immediate jeopardy that began on 10/13/14, and identified on 4/2/15, at 5:48 p.m. was removed on 4/8/15, at 2:35 p.m. after the facility	F 000		

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

Electronically Signed | 05/04/2015

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

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F 000	Continued From page 1 implemented a removal plan.	F 000		
F 151 SS=G	483.10(a)(1)&(2) RIGHT TO EXERCISE RIGHTS - FREE OF REPRISAL The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to honor and protect resident rights for 2 of 2 residents (R3, R49) who were denied access to their private room, personal belongings and/or resident bathroom. In addition, the residents were denied their right to make decisions about their daily care despite facility knowledge of rights restrictions. R3 sustained psychosocial harm due to the rights restriction. Findings include: R3's facesheet dated 4/1/15, included diagnoses of subdural hemorrhage (bleeding in the brain), diabetes, hypertension (high blood pressure), depressive disorder, glaucoma, cataract, atrial fibrillation (irregular heart beat), convulsions (seizures), anxiety disorder, and history of falls. The quarterly Minimum Data Set (MDS) dated 3/2/15, indicated R3 was cognitively intact, had no behaviors and no mood symptoms. The MDS further indicated R3 required extensive	F 151	It is the policy of Lakeside Medical Center that all resident□s have the right to exercise his or her rights as a resident of the facility and as a citizen resident of the United States. Resident□s have the right to be free of interference, coercion, discrimination and reprisal from the facility in exercising his or her rights. A Negotiated Risk agreement policy and procedure and form has been developed which allows for a resident or a resident□s representative to make an informed decision regarding personal care choices which does not align with the facility recommendations. Resident #3 □A negotiated risk agreement was discussed resident with and completed on 04/17/15.The risks versus benefits were explained and the Resident□s room was rearranged to allow access to her closet. Her alarms were removed and her walker was placed in her room 24 hours per day. Her care plan was reviewed and revised. Resident□s	5/18/15

F000

Lakeside Medical objects to and disagrees with both the findings of non-compliance and the level of deficiency cited. We do not believe that the conditions at Lakeside Medical Center have caused "actual harm" or substandard quality of care.

This Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency.

Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of deficiencies as a condition to participate in the Medicare & Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility.

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F 151	Continued From page 2 assistance of one staff for transfers and ambulation, was unsteady but able to stabilize without staff assistance, had no range of motion deficits, and used a walker and wheelchair. Incident reports were reviewed for R3's falls and R3 had 9 falls between the dates of 7/16/14 and 3/24/15. Following a fall on 7/16/14, the interdisciplinary team (IDT) agreed with the removal of clothing from the closet and placing it into drawers, and a dresser was placed in front of the closet. The social service designee (SSD)-A documented on 7/16/14, that R3 agreed to the night stand and dresser to block the doors to prevent R3 from opening the closet doors. Following a fall on 7/20/14, the IDT note dated 7/21/14 indicated an alarm was placed on her wheelchair and limited her ability to transfer independently. Following a fall on 8/21/14, the walker was removed from her room. R36 was told they were trying to keep her safe. Following a fall on 10/4/14, a chair and bed alarm were put into place. The IDT meeting note dated 10/7/14, R3 had stated, "I don't care if I fall, I want to do what I want." Review of R3's care plan dated as revised 3/17/15 and provided by the facility as current, the care plan mirrored these interventions. A care conference note dated 12/16/14, indicated R3 questioned the need for alarms and was reminded of her frequent falling. No changes were made at that time. A progress note dated 2/15/15, indicated R3 was crying and upset that someone took her walker out of her room without telling her. R3 was reminded that she could not use her walker without assistance due to safety. R3 was tearful that her walker was taken out of her room and stated she understood she needed	F 151	Fairview case manager/NP had met with resident regarding an opportunity to return to her previous living environment in an assisted living facility. Resident discharged from the facility 4/25/15. Resident #49- Care plan has been reviewed and revised by interdisciplinary team. Family was provided education regarding removal of the door knob cover. Door knob cover was removed on 04/16/15. Bathroom lock was removed during MDH survey. Resident Rights policy was reviewed and revised. Resident council reviewed the Resident Bill of Rights on 04/14/15. All Residents have received copies of the bill of Rights and signed acknowledgements. A letter was written by the Nursing Home Administrator and mailed to all responsible parties along with a copy of The Resident Bill of Rights. A new template was devised for quarterly Resident Care Conferences to ensure Resident Rights are reviewed. The Care Providers Resident Rights pamphlet in the admission packet was replaced by the Your Rights Under the Combined Federal and Minnesota Resident Bill of Rights from MDH. The Care Providers poster on the dining room bulletin board has been replaced by MN Leading Age poster entitled Rights in Healthcare Facilities Resident rights will be reviewed at quarterly care conferences and will offer to Resident Council to add to the agenda of monthly Resident Council meetings. IDT was provided education on resident rights by a licensed social worker	

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F 151	Continued From page 3 assistance with her walker. AN incident report indicated on 3/24/15, at 7:10 a.m. R3 tripped over the wheel of her walker. The bed and seat alarms were replaced, the walker was removed from the room to allow for the area to be free of clutter, and R3 was encouraged to request assistance with tasks. R3 was tearful over fall. R3 made statements, such as, "People fall, I just tripped, I was doing so good." The 24 hour follow-up on the incident report indicated R3 called for assistance during the night as instructed on 3/25/15 and 3/26/15. The IDT note on the incident report, indicated R3 stood up instead of using the wheelchair, so the intervention was to remove the walker from the room at 3:00 p.m. R3 was to go to the nurses' desk at 8:00 a.m. and it would be returned to her for use. A progress note dated 3/25/15, at 7:07 a.m. indicated R3 continues to turn off alarm and self transfer. When reminded to call for help she states, "But I don't want to wait." The Physical Therapy Discharge Summary dated 4/7/15, indicated R3 was independent with gait and 4 wheeled walker from the hours of 8:00 a.m. to 3:00 p.m. From 3:00 p.m. to 8:00 p.m. R3 uses her wheelchair for locomotion and stand by assist for all transfers due to history of increased falls during this time range. "Pt is in agreeance (sic) with this schedule." The Tinetti (balance test) score is 24/28 which identified a medium fall risk. The behavior flow sheets dated for March 2015, indicated R3 almost daily turned off alarms and transferred herself. During an observation on 3/31/15, at 2:59 p.m. R3 was observed in her wheelchair in the hallway.	F 151	consultant on May 4th. Staff will have resident rights education on May 6th and May 7th. Resident interview audits were completed with residents or resident□s representative in regards to access to their personal belongings. Random observation audits of assuring residents have access to their personal belongings will be performed weekly until compliance and quarterly thereafter. Audits will be reviewed by facility QAPI committee. The Administrator or his or her designee is responsible for overall compliance.	

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F 151	Continued From page 4 An alarm and auto-lock brakes were on her wheelchair. During an observation on 4/1/15, at 7:31 a.m. R3's bed had an alarm hanging on it, bilateral upper grab bars were in place, and there was a dresser in front of the closet with a sign on the closet door indicating the clothes were in the dresser. The closet doors were completely obstructed. During an observation on 4/1/15, at 7:36 a.m. R3 was propelling her wheelchair from the dining room, using her feet. An alarm was hanging on the back of the wheelchair and auto-lock brakes were on the wheelchair. During an interview on 4/1/15, at 9:09 a.m. R3 stated the staff put the dresser in front of her closet doors because she fell twice getting things out the closet. R3 stated she doesn't like it and feels like she is getting "punished." R3 stated she would like to be able to use her closet. R3 stated she fell a couple of weeks ago, and tripped over her 4-wheeled walker, so they took away her walker from 3:00 p.m. to 8:00 a.m. R3 stated she asked them, "What if I trip over my bed, will you take away my bed? What if you [staff] fall, what will they take away from you?" R3 said she joked about it but the restrictions don't make her feel very good. R3 stated each time they restrict her, she feels like she is being punished. R3 stated she has said that to the nurses and the director of nursing (DON) replied that she is not being punished, but that it is for her safety. R3 reported that she has asked them to take the alarms off and they continue to tell her in a couple of weeks, but then they said a couple of months, and when she reached the 2-month mark, she fell again.	F 151		

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F 151	Continued From page 5 R3 stated she did hit her head each time, so they keep telling her it is for her safety. R3 repeated that the staff put her walker in the office at 3:00 p.m. and she has to go down at 8:00 a.m. and ask for it. R3 stated the restrictions are affecting her depression and that she feels like she is in prison. R3 spoke in a stuttering and halted speech pattern, and stuttered more when she spoke of her restrictions and how they made her feel. R3's voice broke at one point, and she had a sad facial expression throughout the interview. During an interview on 4/1/15, at 2:36 p.m. R3 stated she cannot get into her closet and wanted to be able to hang some of her clothes in the closet. R3 stated her clothes are in different drawers around the room now, and the drawers are too full so the clothes are wrinkled. R3 stated she does not like to wear wrinkled clothes. R3 stated she felt better when her clothes were not wrinkled. R3 talked about not having her walker and said she has to go down to the desk and get it every time, and would like to have it in her room because it is an effort to get down there. She further stated it was her walker and she wants it in her room. R3 stated when she is using the walker, it is the only time she has any independence. When she does not have the walker, she uses the wheelchair and stated it is easier to get around with the wheelchair, but wants to maintain her independence as much as she can and have the choice of when she was able to use the walker. R3 further stated that she felt like she is punished and in prison because she has lost some of her freedoms. R3 stated she felt more secure if the walker was in her room, because it is hers and is used to using it when she wants to.	F 151		

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F 151	Continued From page 6 During the interview on 4/1/15, at 2:36 p.m. R3 continued that she feels she has to do things according to "their [facility] rules." When they took away her walker, R3 stated she felt like, "Why me? I am not doing anything wrong." R3 stated, "Anybody can fall, but I can't get up off the floor, they have to help me." R3 further described how she felt when she is restricted from her walker and her closet, by saying she has a loss of pleasure and felt more agitated when they took the walker away. R3 stated she still felt agitated. R3 described agitated as being more tied down, and said the alarms add to that feeling. She said that in a way, she felt worthless and not like a normal person because she doesn't have the freedom she would like to have. R3 stated that not having the choice of using the walker, not getting into her closet, and the alarms, made her feel like she doesn't have the same rights as a "normal person." R3 stated she has asked about the alarms and has told the staff she doesn't like them. R3 stated she said OK to the restrictions of the closet and the walker because she felt she did not have a choice, and felt disappointed and restricted. R3 stated she felt like she gave up and there was nothing she could do about it. R3 stated she is working toward getting them back. R3 stated the alarms go off at night and she felt she was disturbing her roommate every time she moved. R3 stated she has not talked to the social worker or nursing about her feelings, because she felt it would do no good, as it is the facility rules and she was resigned to following the rules. R3 repeated that they tell her it is a safety thing, but still felt she wanted to use the closet and walker whenever she could. R3 had a sad facial expression throughout the interview and a furrowed brow when talking about her restriction from using her closet and having to	F 151		

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F 151	Continued From page 7	F 151		

leave the walker in the office. When the interview was done, R3 stated she was going to take her walker back out to the day room, but looked at her watch and acknowledged it was after 3:00 p.m., so stated she could not use her walker now.

During an interview on 4/2/15, at 4:45 p.m. the social services designee (SSD)-A stated they promote resident participation in the care planning process by asking them (residents) specific questions about how staff treat them and preferences, such as bed times, bathing, and clothes. SSD-A stated when residents have a change in their daily life and care, they have a care conference. SSD-A stated she has visited with R3 many times and said at times, R3 is very copasetic about her restrictions. SSD-A stated they have talked about risk vs. benefits regarding her falls, but that R3 has some difficulty in reasoning later in the day. When asked about the restrictions R3 had and the impact on R3's rights, SSD-A stated of course they impinge on her rights. SSD-A stated she was given her walker back but had another fall with her walker. When asked if the restrictions impacted R3's dignity, SSD-A stated, "Yes, absolutely." SSD-A stated R3 is able to make decisions regarding her care. SSD-A denied that R3 has expressed concerns about her alarms and has not expressed that she is not treated like a normal person to her. SSD-A reiterated it was a safety issue.

During an interview on 4/3/15, at 9:29 a.m. nursing assistant (NA)-E stated they monitor R3 in the morning and her walker is in the medication room. NA-E stated R3 will say, "If I trip over my bed, will you take it away? If you fall, what do they take away from you?" NA-E stated R3 is able to make decisions about her daily care and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 151	Continued From page 8 that other decisions are reasonable. During an interview on 4/3/15, at 9:36 a.m. the licensed practical nurse (LPN)-F stated R3 gets to use her walker between 8:00 a.m. and 3:00 p.m., as therapy said she could be independent during those times. LPN-F stated R3 responds well when it is explained to her, but has shown frustration with needing more assistance. LPN-F denied R3 has reported anything about not getting into her closet. During an observation and interview on 4/6/15, at 8:52 p.m. R3's walker was in her room. R3 stated she has to bring her walker down to the desk at 3:00 p.m., but just didn't do it tonight. R3 stated she gets tired out sometimes and then uses her chair. R3 stated that when they take her walker to the desk she feels disappointed. R3 stated she feels, "like I'm a naughty child and they are taking my toys away." R3 stated when she can't use her closet and can't hang her clothes up, she feels upset and like she is being punished. R3 stated the staff say it is only because they are watching out for her safety. R3 stated she felt fine at this facility before they took the walker and closet away, except she didn't like the alarms. R3 stated she felt like being in a nursing home, it was her last place and home, and it was just the way it is. R3 stated she was feeling lonely when she came to the facility, but felt innocent then because she hadn't done anything wrong. R3 stated one of her children had fallen and hit their head and died, so realizes the risks of falling and hitting her head. R3 stated she wants to feel like she is a person, and does not want to be pushed around and watched with everything she does. R3 stated, " I have lived these years as I am, and I have had problems,	F 151		

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	245374	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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but that's the way it is." When asked if she understood what could happen if she fell and hit her head, R3 replied, "I know that it could kill me." R3 then stated she would like to have more freedom.

During an interview on 4/7/15, at 9:24 a.m. with the director of nursing (DON) and the assistant administrator (AA), they stated R3 had fallen after using the closet and they tried to adapt the closet first, such as lowering the bar for her. The DON stated R3 was in agreement to the plan and the risk benefits have been discussed with her, but not documented. They stated the dresser space gave her more space than her closet provided. They explained that PT had seen her and and have upgraded her to having her walker between 8:00 a.m. and 3:00 p.m. When told how R3 was feeling, the DON stated that was not the intent, but that it was for her safety.

R49's quarterly MDS dated 1/26/15, identified R49 had diagnoses that included dementia, anxiety, depression, seizure disorder or epilepsy, and psychotic disorder. the MDS also identified R49 had severe cognitive impairment, and required extensive assistance with all activities of daily living (ADLs) except for eating.

R49's care plan dated 2/28/15, identified R49's room door was to be closed when resident was out of her room to discourage her from going into her room alone. The care plan also identified that the door knob cover was applied to her door knob to deter R49 from entering her room alone for her safety. The care plan also identified R49 will participate in independent activities of choice, has a TV in her room, and has a goal to improve ADLs and self-care ability.

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F 151	Continued From page 10 On 3/30/15, at 5:17 p.m. observed bathroom lock on the top of R49's bathroom door out of R49's reach. The lock was secured and locked to prevent R49 from getting in. During an observation on 04/01/15, at 10:11 a.m. a large, white plastic child-proof door knob cover was applied to the outside of R49's bedroom door, visible to the public in a high traffic hallway. R49 was outside her bedroom door struggling to open the door to her bedroom. After several failed attempts, R49 gave up and began to self-propel down the hallway very slowly, grabbing on to rails to pull herself along the distance of the hallway. During an observation on 04/01/15, at 10:20 a.m. R49 returned to her bedroom door and tried to enter again. R49's bedroom door was closed, with the child proof door-knob covering on the door knob to prevent R49 from getting into her room. R49 continued to try to turn the door knob to get in to her room. After R49 could not get into her room, she started to call out "help, help, help" and kicked her bedroom door in frustration. The physical therapist (PT)-A who was walking down the main hallway quickly took R49 away from the front of her bedroom door, and pushed R49 down the hallway and stated, "Let's follow everyone down here. " PT-A pushed R49 down to the dining room and left the area. During an observation On 04/02/15, at 2:25 p.m. there was a bathroom lock on the top of R49's bathroom door out of R49's reach. The lock was secured and prevented R49 from getting in. During an interview on 03/30/15, at 6:56 p.m. R49's family member (FM)-B was interviewed.	F 151		

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F 151	Continued From page 11 FM-B stated she has met with the nurse practitioner (NP), various nurses, and DON regarding her concerns about the lock on the bathroom door and the plastic door knob cover on the outside of her bedroom door. She stated, "I did not like that she was restricted from her room, and the door knob cover prevents [R49] from opening the door and entering her room." During an interview on 04/02/2015, at 9:42 a.m. social services designee (SSD)-A stated the door knob and bathroom lock was to keep her safe. SSD-A stated, "Knowing [R49], it was probably the last thing the interdisciplinary team came up with." SSD-A stated, "[R49] is allowed to go into her room in the afternoon for a nap." SSD-A was asked if other interventions other than the child-proof door knob and bathroom lock were considered, and what her opinions were regarding the child-proof door knob and bathroom lock. SSD-A smiled and stated, "I know you're gonna quote me," and did not answer the questions. SSD-A then stated, "I understand your point about the dignity and privacy of the external door knob and the bathroom lock." SSD-A added, "The bathroom door lock has nothing to do with [R49], it is still there from years ago." SSD-A stated the child proof door knob was on R49's care plan. During an interview on 04/02/15, at 2:00 p.m. activities aide (A)-A stated she knew R49 well and she had worked at the facility for over three years. A-A stated R49 was not allowed to go into her room alone, and she has a safety handle on her door knob so she can't go into her room. A-A stated R49's bathroom lock could be used to keep R49 out. A-A added. "I've seen her try to get in with the safety door knob on, and will call out	F 151		

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when she can't get in." A-A stated, "Having the child proof door knob on her door is troubling for [R49] as it would be for anyone knowing that is your room and you can't go in." A-A stated they receive resident rights training annually and on hire. A-A stated that this could be not be following the resident rights.

During an interview on 4/2/15, 2:27 p.m. NA-A stated R49 tries to get into her room and kicks the door when she can't get in. NA-A stated R49 does her normal yelling out "help " when she can't get into her room. NA-A stated, "We usually try to detour her when we see her trying to get into her room." NA-A confirmed the bathroom was locked and stated, "The bathroom lock is to keep her out of there because she has tried to self-transfer." NA-A added. "[R49] has always been a very independent person, I would think it is discouraging to her when she can't go into her room."

On 4/2/15, at 2:30 p.m. NA-C reviewed R49's NA care sheet, and quoted the document reading,"The reasoning for [R49's] door knob is to keep R49 out of her room."

On 4/2/15, at 4:43 p.m. SSD-A stated she received some training from the previous social worker on some resident rights and stated, "The previous social worker kind of trained me on resident advocacy." She added she has been the SSD for 3 years. SSD-A stated the bathroom door lock is from a previous resident. SSD-A stated she definitely agrees that the knob is a dignity issue, as people can see her name on the door and the child proof door knob. She stated she is on the fence if the door knob is a violation of R49's resident rights. SSD-A stated she would

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F 151	Continued From page 13 feel comfortable challenging administration if she felt strongly enough that this was a violation of R49's resident rights. On 4/3/15, at 8:45 a.m. registered nurse (RN)-B stated the bathroom door lock should be care planned. RN-B stated she thought it was, but couldn't guarantee it. RN-B stated the child proof knob reminds R49 that she can't go in to her room, and R49 calls out when she can't get into her room. RN-B stated, "She [R49] doesn't listen, she is a very independent lady, [R49] is used to getting what she wants, and doing what she wants." RN-B stated R49 knows which room is hers, and might go into other resident rooms because she can't get into her own room. RN-B stated R49 has told her "they are trying to keep me out of my room." RN-B stated R49 can be in her room before she gets up in the morning, for toileting, her afternoon nap and when she has visitors. RN-B stated, "There has been times when [R49] can't get into her room and she calls out, and then they keep her out in the hallway." RN-B added R49 has no access to her room when she is confused or calling out "help me." RN-B stated she felt this was a dignity issue, but not a resident rights violation. She stated. "I don't remember if the facility did any risk/benefit education about the door knob or bathroom lock." RN-B stated, "[R49] didn't have a say about the door knob or bathroom lock, it was explained to her, it was my decision over hers." RN-B stated some of R49's children feel R49 should be able to come and go from her room as she feels like it and stated, "I also agree with that." RN-B stated R49 spends most of her day wandering up and down halls. On 4/3/15 9:51 a.m. the DON stated, "We	F 151		

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F 151	Continued From page 14 identified high risk fall areas were her bedroom and bathroom." She stated they would tell R49, "We have to keep the door closed to keep you out here with us." The DON stated R49 would wiggle and play with her doorknob and she has seen/heard her call out "help" when she couldn't get into her room. She stated, "I get your concern with dignity." The DON stated a thorough listing of risk and benefits for each intervention was not done. She added the lock on the bathroom should have been taken off, as it was put on years ago for someone else. The DON stated, "Staff are telling me that they thought it was supposed to be used for [R49]." She stated, "What we need to do now is discuss concerns with IDT and decide if this is a dignity issue, as a team we are looking at the infringement of [R49's] rights to get into her room to get at her things." On 04/03/15, at 11:56 a.m. R49 stated, "The door knob bothers me" and "I feel locked out of my room." R49 added, "I have to stay out of my room until it gets opened, I have to sneak in and whenever they don't lock the door I go in." R49 stated, "I yell at staff when I can't get into my room, I told them I don't like it, they should take the knob off so I can get into my room when I want to, I rent the room so they shouldn't keep me out." According to "Your rights Under The Combined Federal and Minnesota Residents Bill of Rights," MDH, 7/1/07, identified the facility violated R49's rights to dignity, self-determination and participation, and personal property. The right to dignity is to care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality. The right to self-determination and	F 151		

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F 151	Continued From page 15 participation to make choices about aspects of your life in the facility that is significant to you. The right to personal property is you have the right to retain and use personal possessions including some furnishings, and appropriate clothing.	F 151		
F 153 SS=D	483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide requested copies of medical records for 1 of 1 resident (R36) whose family requested record information following a hospitalization. In addition, the facility policy does not provide for access to medical records within 48 hours and requires a written request for medical records. Findings include: R36's family member (FM)-A stated during an interview on 3/31/15, at 11:33 a.m. FM-A had made a request for the medical records regarding R36's medication error and resulting	F 153	It is the policy of Lakeside Medical for residents or their legal representative to have access upon written or oral consent to medical record within 24 hours excluding weekends and holidays; and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any unused portions of them upon request and 2 working days advance notice to the facility. Resident #36/FM-A received a copy of the medical record for stay at Lakeside Medical Center.	5/18/15

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F 153	Continued From page 16 hospitalization. FM-A stated the records from the nurse practitioner (NP) were signed for and received, but the records related to the hospitalization had not been received. FM-A was told that it was not the facility policy to release those records. During an interview on 4/7/15, at 8:45 a.m. the assistant administrator (AA) stated when a resident or family member requests the medical records, they sign a release, which is then given to medical records staff. AA stated that it is against their policy to release nursing notes, but stated FM-A did get the nursing notes. During an interview on 4/7/15, at 2:40, AA stated she was there when FM-A asked for the copies of medical records, and she had actually wanted the copies of the nurse practitioner visit notes and got what was requested. The AA stated she helped the family member fill out the release of information for the NP notes and brought it to medical records staff. The information was then given to FM-A. The facility policy and procedure for patient access to protected health information dated 6/1/11, indicated patients have the right to access, inspect, request amendments to and obtain a copy of their medical record for as long as it is maintained. The policy also indicated a written request to access their protected health information must be made, and the facility then will act on the request no later than thirty days after receiving the request. If the request will take more than 30 days to act on the request, the facility may take an additional thirty days to act, provided, they provide a written notice to the patient of the delay and the date by that it will be	F 153	The policy and procedure has been reviewed and revised for access to medical records. The policy was reviewed with resident council on 4/14/2015. Staff have been educated on policy regarding resident and resident representative access to medical records. Medical records department will audit any request for access or copies of the resident record. Results of audits will be reviewed at facility QA&A committee. RHIT is responsible for overall compliance	

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F 153	Continued From page 17 completed. The policy further indicated the decisions regarding a request to access medical records will be made to the medical records department which may involve the medical director, privacy officer and/or legal counsel.	F 153		
F 156 SS=F	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the	F 156		5/18/15

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F 156	Continued From page 18 facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.	F 156		

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F 156	Continued From page 19 The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide residents of the facility with notification of all their rights under Federal and State law. This had the potential to affect 31 of 31 residents of the facility, and any residents admitted to the facility. Findings include: Upon review of the facility's admission packet, the facility provided each resident/representative a copy of "Resident Rights, Statement of Policies and Rights for Medicare and Medicaid Certified Nursing Facilities." However, this document contained only the State rights. There was also a poster on the dining room bulletin board that contained the same rights as the copy provided at admission. The combined federal and Minnesota Resident Bill of Rights had 42 rights identified. The facility provided written documentation of State resident rights, but failed to notify residents of their Federal rights as a nursing home resident. During an interview on 4/2/15, at 10:18 a.m. social services designee (SSD)-A stated she had been in her position for 3 years. The current rights information has been used since she has been in her position, as it had been in place when	F 156	It is the policy of Lakeside Medical Center that all residents are informed both orally and in writing in a language that the resident understands his or her rights and all rules and regulations governing resident conduct and the responsibilities during the stay in the facility. Resident Rights policy was reviewed and revised. Resident council reviewed the Resident Bill of Rights, received copies, education was provided, and an acknowledgment was signed on 4/14/2015. R3 was in attendance at this meeting. A letter was created by Nursing Home Administrator along with a copy of The Resident Bill of Rights and was provided to all residents or their responsibly party. The Care Providers Resident Rights pamphlet in the admission packet was replaced by the Your Rights Under The Combined Federal and Minnesota Resident Bill of Rights from MDH. The Care Providers poster on the dining room bulletin board has been removed and Leading Age□s Rights in Healthcare Facilities sign has been hung at	

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F 156	Continued From page 20 she assumed the role. SSD-A stated she was not aware that this list of rights was incomplete. SSD-A acknowledged no other rights were reviewed or provided to residents and/or their representative. R3 stated she had not been informed of resident rights beyond receiving the booklet of information at the time of admission. According to the quarterly Minimum Data Set (MDS) dated 3/2/15, R3 had a brief interview for mental status (BIMS) score of 14, which indicates she is cognitively intact. The MDS also indicated R3 had no signs or symptoms of depression and no behaviors that were distressing or disruptive to the resident or the facility. In an interview on 4/6/15, at 4:02 p.m. R3 stated she attended the resident council meetings. R3 stated she knew they received a "booklet" on resident rights upon admission, but hadn't heard about rights since then. During an interview on 4/6/15, at 4:49 p.m. the SSD-A stated she attended resident council meetings on occasion and the meetings are typically focused on activities. SSD-A stated that she had never done a presentation or formal review of resident rights in her tenure as social service designee. During an interview on 4/8/15, at 1:54 p.m., the activities director (AD)-A stated she had been in her position for about 3 years and she attended the resident council meetings and took minutes. In her time in that position, AD-A did not recall a formal agenda item or discussion of facility rules or resident rights.	F 156	wheelchair height near the 2 AB Activity board. Resident rights will be reviewed at quarterly care conferences and facility will offer to Resident Council to add to the agenda of monthly Resident Council meetings. IDT was provided education on resident rights by a licensed social worker consultant on May 4th. Staff will have resident rights education on May 6th and May 7th. Resident interview audits were completed on residents who were interviewable. Random observation audits will be performed weekly until compliance and quarterly thereafter. Audits will be reviewed by facility QAPI committee. The Administrator or his or her designee is responsible for overall compliance.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		5/18/15

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F 157	Continued From page 21 A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely notice of room change to 1 of 1 resident (R68) reviewed for notification of change.	F 157	It is the policy of Lakeside Medical Center to inform the resident and the resident□s representative when there is a room change.	

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F 157	Continued From page 22 Findings include: R68's admission record identified he was admitted to the facility on 3/25/15, after a hospitalization for acute respiratory failure. Other pertinent diagnoses identified included aspiration pneumonia and chronic airway obstruction. According to an admission progress note dated 3/25/15, R68 was alert and oriented. During an interview on 4/1/15, at 10:01 a.m. social services designee (SSD)-A was observed to enter R68's room and close the door. Through the closed door, SSD-A was heard telling R68 that it was "moving time." Upon entry to R68's room on 4/1/15, at 10:06 a.m. SSD-A was taking clothes out of R68's closet and laying them on R68's bed. SSD-A was telling R68 that he was moving to a room closer to the desk so staff could keep a better eye on him. R68 asked, "Why?" SSD-A responded, "I just told you!" When asked to clarify, SSD-A stated that R68 did not know about the move until he was informed a few minutes ago. SSD-A then pushed the bed and stack of clothes out of the room. During an interview on 4/1/15, at 10:18 a.m. R68 stated he didn't know why he needed to be closer to the nurse's desk. He stated he didn't like it. When asked if he would indeed move, R68 sighed heavily and stated, "I guess so." On 4/1/15, at 10:19 a.m. SSD-A knocked and re-entered R68's room. Shortly after, nursing assistant (NA)-B entered R68's room. R68 stated that he was "dumbfounded" and asked SSD-A why they were moving him. SSD-A replied that by moving he could be closer to where everyone	F 157	Social Services followed up with R68 on 04/10/15 regarding his new room. R68 stated he liked his new room and knew his roommate from his previous living environment and they liked to talk about farming together. R68 was discharged from the facility on 04/15/15 to his previous living environment. On 04/02/15 a policy for room change was written. Policy for room change was reviewed and revised to include examples of an emergent need that could constitute a room change without the consultation of The Director of Nursing or Social Services, which may include if the resident is at risk for harming themselves or at risk for harming others. The room transfer 7 day notice form was updated for resident/resident representative to sign in the event of a room change which informs them of their right to appeal and includes contact information for the Ombudsman and OHFC. Any planned room change will be reviewed with interdisciplinary team in the daily meeting along with notification of resident and responsible party. Unplanned room change will follow Room Change policy and procedure. Staff were educated on policy and procedure for room change on 04/28/15 via the communication book and again at inservice on 5/6/15 and 5/7/15. An audit on each room change will be completed for next 3 months for compliance with policy and procedure. Facility Q&A committee will review audit results for compliance. Director of Nursing is responsible for overall	

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F 157	Continued From page 23 was, that he knew the roommate, and there was more going on there. SSD-A told R68 that he was not supposed to transfer himself and that he was supposed to get help so that he can get better. R68 stated that when he was in his Assisted Living he did everything himself. SSD-A agreed and stated that he is getting physical therapy so that he can get stronger in order to get back to his Assisted Living. After a discussion about signing admission papers, the SSD-A asked R68 if he had any more questions. She stated, "If you don't have any more questions, can I finish my job?" As she was talking, SSD-A was packing up R68's personal items and putting them on a bedside table to move them. SSD-A left the room at 10:30 a.m., and R68 was still sitting in the recliner with a puzzled look on his face. During an interview on 4/1/15, at 10:36 SSD-A stated that the decision to move R68 was made in the interdisciplinary team (IDT) meeting that morning because R68 didn't understand he can't do things independently. SSD-A stated, "He needs to ask for help." SSD-A stated she gave notification right before she moved R68. She stated, "We can't just move someone without their permission." SSD-A continued to explain that R68 made his own decisions, so his family was not called. When asked if R68 liked the idea of moving, SSD-A stated, "Oh yeah he likes the idea, he moved didn't he?" During a follow-up interview on 4/1/15, at 1:33 p.m. R68 was sitting in his new room. He continued to state he didn't understand why he had to leave his old room. His new room was a shared room.	F 157	compliance.	

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F 157	Continued From page 24 During a follow-up interview on 4/2/15, at 10:18 a.m. SSD-A stated the move was for R68's safety. He had transferred himself the night and morning before the move to his new room. The IDT team decided that a move to a room closer to the nurses station was better than putting an alarm on R68 stating, "We don't use alarms in that area [referring to the area R68 was originally living in]." On 4/2/15, at 1:42 p.m. a policy on room change was requested. An unsigned post-it note was received back from the facility, "No policy on room changes."	F 157		
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.	F 205		5/18/15

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F 205	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written notification of bed-hold was provided within 24 hours for 1 of 1 residents (R36) who was transferred to a hospital. Findings include: R36 was transferred to the hospital three times between 10/1/14 and 4/1/15. Two Therapeutic Leave and Bed-Hold notices were viewed, one for R36's first and third transfers to the hospital. Each bed-hold notification indicated family member (FM)-A was verbally notified of the bed-hold. There was no indication the facility provided the written bed-hold policy to FM-A. During an interview on 3/31/15, at 11:33 a.m. FM-A stated R36's return from the hospital was not a problem and R36 was able to return to his room. FM-A did not recall receiving written notification of the bed-hold policy while R36 was discharged to the hospital. During an interview on 4/3/15, at 8:25 a.m. the director of nursing (DON) stated they do have a bed-hold form, but because of the facility's low census, they do not usually issue it. The DON stated the facility does not receive payment when a resident is admitted to the hospital and assures the family that the resident's bed will be here when they return. During an interview on 4/7/15, at 8:45 a.m. the assistant administrator and the DON repeated the facility did not need a bed-hold when the census was so low and said they would check whether	F 205	It is the policy of Lakeside Medical Center to provide written information to the resident and representative of the duration of the bed hold policy under State of Minnesota plan. Resident#36- Resident and resident/representative were provided a copy of the bed hold policy. The policy and procedure for resident bed hold was reviewed and revised to include instructions to send a copy of the bed hold policy with the resident at the time of transfer. It also was updated to state that if the resident is unable to sign the bed hold at the time of the transfer a verbal agreement with the resident□s representative will be obtained and a copy will be mailed for a signature. The facility has a capacity for 46 beds and currently has a census of 25. Under Medicaid it is not likely occupancy rate of 93% would be reached. Written notification of bed hold information is provided on admission in admission packet as well as when a resident is transferred to a hospital. The hospital transfer form has been updated with a check box to verify bed hold information was provided at time of transfer. Nursing staff were educated on bed hold policy via communication book on 04/17/15 and again at inservice on 05/05/15 and 05/06/15. An audit for compliance with bed hold policy and procedure will be performed on every discharge/transfer for 3 months.	

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F 205	Continued From page 26 the bed-hold was sent out to FM-A for a signature. No additional information was received. The undated facility policy and procedure for, Transfer, Discharge, Leave of Absence and Termination of Agreement, directed the facility will provide the resident with written information regarding the facility's bed-hold and readmission policies if a resident is hospitalized. The policy further indicated if the resident has made arrangements to reserve a place in the facility, a place will be held at a daily rate equal to the charge for standard care services.	F 205	Results of audits will be reviewed with facility QAPI committee. The Administrator/designee is responsible for overall compliance.	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		5/18/15

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F 225	Continued From page 27 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to immediately report neglect of care to the State agency, and failed to conduct a thorough investigation of the incident, for 4 of 6 residents (R49, R39, R58) with significant medication errors. In addition, the facility failed to immediately report to the State agency (SA) and thoroughly investigate allegations of abuse/neglect/mistreatment for 3 of 6 residents (R33, R49, R41) reviewed for abuse/neglect/mistreatment. The facility also was investigating allegations prior to reporting to the SA. Findings include: R49's significant medication error was not immediately reported to the SA as neglect of care, nor was a thorough investigation completed. R49's Diagnosis Report dated 4/3/15, identified	F 225	It is the policy and the procedure that all alleged violations involving mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of resident property are immediately reported to the Administrator and other officials in accordance with state law. Resident# 33- Resident has expired. Resident #39-Resident has been discharged. Resident #41-A report was made to the state agency on 04/02/15. The report came back from OHFC AS non-substantiated on 04/09/15. Follow-up was done with resident and family. Care plan was reviewed and revised to include that resident at times may make offensive statement towards others. Resident #49 □ A report was made to the state agency on 04/02/15. The report came back from OHFC as	

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F 225	Continued From page 28 R49 had diagnoses of diabetes, dementia, and explosive personality disorder and hypertension. R49's November, 2014, Medication Administration Record (MAR) revealed R49 had been receiving the following medications: -Keppra (anti- seizure), 250 milligrams (mg) by mouth twice daily for seizures, - metoprolol tartate (an anti-hypertensive) 12.5 mg by mouth twice daily for hypertension - Trazodone (an anti-depressant) 50 mg by mouth twice daily for anxiety, depression and mood disorder - melatonin (supplement used for sleep) 3 mg by mouth before bed for insomnia -Tylenol 1,000 mg by mouth before bed for degenerative joint disease A facility Medication Incident Report dated 11/8/14, revealed R49 had received another resident's (R33) medications at 5:15 p.m. The Incident Report further revealed R49 had incorrectly received the following medications: -Seroquel (an antipsychotic medication)12.5 mg by mouth - Lasix (a diuretic) 20 mg by mouth - Propranolol (anti-hypertensive) 20 mg by mouth The facility Medication Incident Report dated 11/8/14, further revealed the cause of the error had been distraction and failure to identify the resident prior to administering the medication. The report also revealed the nurse had been counseled regarding rules of medication pass. The Incident Report identified the common entry point (CEP) was not notified as R49 had no injury. The Incident Report lacked any indication of SA notification of the significant medication error. R39's significant medication error was not immediately reported to the SA as neglect of care, nor was a thorough investigation completed.	F 225	non-substantiated 04/09/15. Follow-up was done with resident and family. Care plan was reviewed and revised by interdisciplinary team to include assist of two with bathing as needed. Resident #58- Resident has been discharged. The facility policy on Abuse reporting has been reviewed and revised to include immediate reporting to Administrator, state agency and Common Entry Point of any mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of resident property, resident to resident altercation, and significant medication errors. Residents will be monitored for mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of resident property, resident to resident altercations, and significant medication errors through shift to shift report, daily with cares and with interdisciplinary team meetings. All reports will be investigated and root-cause analysis performed. Medication Error form was updated to include an investigation and root cause analysis. Ongoing one on one education regarding reporting has been performed. Staff will have formal education on 5/6 and 5/07/15 on abuse prohibition and immediate reporting procedures as well as investigative techniques. Random audits are performed alternating shifts daily by reviewing occurrence reports, shift report and 24 hour board for potential indicators of abuse, neglect, maltreatment and for injuries of unknown	

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F 225	Continued From page 29 R39' Diagnosis List dated 4/3/15, identified R39 had diagnoses of diabetes, chronic kidney disease, and long term use of insulin and edema. Review of R39's January 2015, MAR and physician orders revealed R39 was receiving the following medications : -Novolog insulin sliding scale based on blood sugars checked before all meals and before bed - Novolin insulin 37 units in the morning and 30 units in the evening -Levaquin (antibiotic) 750 mg one tablet by mouth -Prednisone (oral steroid) 10 mg (take 2 tabs) by mouth -Plavix (an anti-platelet) 75 mg by mouth -Synthroid (used for hypothyroidism) 88 micrograms (mcg) -Claritin (allergy) 10 mg by mouth -Toprol (anti-hypertensive) 50 mg by mouth -Lisinopril (anti-hypertensive) 2.5 mg by mouth -Lasix 80 mg by mouth - Zocor (cholesterol lowering) 40 mg by mouth A facility Medication Incident Report dated 1/31/15, revealed R39 had received another resident's (R58) medications at 4:35 p.m. The Incident Report further revealed R39 had incorrectly received the following medications: -Metformin XR (oral hypoglycemic agent) 1000 mg -Glipizide (oral hypoglycemic agent) 5 mg -Neurontin (medication used for neuropathy pain) 600 mg A multivitamin and fish oil. The 1/31/15, Incident Report further revealed the cause of the medication error was distraction and the nurse's failure to identify the resident prior to administration. The Incident Report lacked indication of SA notification regarding the significant medication error.	F 225	origin. All occurrences are reviewed at IDT meeting. Audits will be reviewed at facility QAPI meeting for trends and patterns. Administrator/designee is responsible for overall compliance.	

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F 225	Continued From page 30 R58's significant medication error was not immediately reported to the SA as neglect of care, nor was a thorough investigation completed. R58's Diagnosis List dated 4/3/15, identified R58's diagnoses of cardiac murmur, hypertension, diabetes and urinary incontinence. Review of R58's January 2015, MAR and physician orders revealed R58 received the following medications: -Metformin 1,000 mg by mouth -Lovenox (blood thinner) 40 mg injected daily -nicotine patch 21 mg/24 hr daily topically -Prilosec (anti-reflux) 20 mg by mouth daily -Flomax (used for enlarged prostate) 0.4 mg by mouth -aspirin 81 mg by mouth -Centrum silver (multivitamin) one tablet by mouth -Lisinopril (antihypertensive) 10 mg by mouth -Lutein (eye vitamin) 20 mg by mouth -Albuterol/ipratropium nebulizers (used for breathing problems) nebulizer solution three times a day A facility Medication Incident Report dated 1/26/15, revealed R58 had received another resident's (R33) medications. The Incident Report identified R58 had received Lasix (diuretic) 80 mg by mouth. The Incident Report identified the cause of the medication error to be distraction. The staff member was instructed to identify patient before giving medication. The Incident Report also lacked indication of SA notification as well as physician response to the medication error. On 4/7/15, at 12:01 p.m. the medical director stated he would consider a significant medication error to be one that caused harm or could potentially cause harm to the patient. He confirmed that R39, R58 and R49's medication errors could all have been potentially significant.	F 225		

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F 225	Continued From page 31 A policy was requested regarding the reporting of significant or potentially significant medication errors however, none was provided. R33 sustained two injuries of unknown origin (defined as a source of injury which was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one point in time or the incidence of injury over time) which were not reported to the SA immediately, and lacked a thorough investigation to determine if abuse/neglect or mistreatment had occurred. R33's Diagnosis List identified diagnoses which included dementia. R33's quarterly MDS dated 1/27/15, identified R33 had severe cognitive impairment, and behavior symptoms of physical and verbal actions towards others as well as rejection of cares. The MDS also identified R33 needed extensive assistance of facility staff with all activities of daily living. R33's care plan dated reviewed on 2/15/15, identified R33 had severe cognitive impairment, short and long term memory deficit, moderately impaired decision making skills, poor safety awareness, was not safe and had physically declined requiring more staff assist. R33 was also identified as having "delusions" of staff going in the resident's room at night. The facility's Vulnerable Adult Assessment dated 2/16/10, indicated R33 was at low risk of vulnerability due to minor forgetfulness, minimal supervision needed for self preservation and an indication R33 was at the facility for short term	F 225		

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	245374	A. BUILDING _____ B. WING _____	04/08/2015

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placement. The facility was unable to provide a more recent vulnerability assessment which would reflect R33's cognition and assistance requirements and vulnerability risk at the time of the incidents.

On 9/10/14, R33 was discovered to have bruising of unknown origin measuring 6 centimeters (cm) by 2 cm on the left inner thumb. R33 was unable to recall how the injury occurred. The facility did not report the bruise to the SA. On 9/12/14, a note was made on the incident report for R33's bruise which indicated R33 was combative with cares on the evening of 9/9/14, had been swinging her hands and likely bruised thumb at that time, no neglect or mistreatment was suspected. A secondary form dated 9/10/14, titled, "Incidents of Unknown Origin Investigative Tool" identified no need to report to the SA as could assume that R33 slammed hand in drawer. The form further indicated the staff member did not observe bruising on R33 on 9/9/14. The investigation was incomplete and failed to rule out possible abuse/mistreatment.

On 12/3/14, at 4:00 p.m. R33 was found to have multiple bruises on both lower arms which were not noted the night before by the staff member completing the form. The form lacked the number and the measurements of the bruises found on R33. A nursing progress note dated 12/3/14, at 11:58 p.m. indicated the nurse had been notified of R33's multiple bruises on her bilateral upper extremities. R33 was unable to state how the bruises happened. The "Incident of Unknown Origin Investigative Tool" staff interview section revealed the following statements:
On 12/3/14, 4:00 p.m. R33's bruise was not noticed the day before and the staff did not know

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what happened.
On 12/4/14, 6:50 a.m. no direct care was provided to R33 by the staff member nor was any new bruising noted with medication administration.
On 12/4/14, 12:30 p.m. no bruising had been noted on previous shift on 12/3/14.
On 12/4/14, R33's bruises had not been observed by staff prior to R33's bath, staff member didn't think it was out of the ordinary.
A summary of the investigation indicated R33 bruised easily and liked to layer clothing. Although the bruising remained an injury of unknown origin, there was no further investigation and the injuries were not reported to the SA.

On 4/1/15, at 10:12 a.m. the assistant administrator (AA) stated R33 could have easily bruised the left thumb while rummaging in drawers, or by picking up a six pack of bottled soda. R33 was a very busy person. The AA also stated she reviewed progress notes, interviewed staff and looked at medical conditions and/or diagnoses of a resident to determine the cause of an injury of unknown origin prior to reporting the incident to the SA to "see if it's reportable." The AA further stated the decision making tree for reporting injuries of unknown source was used to determine whether R33's bruising should be reported to the SA, and did not feel the bruising needed to be reported based upon her investigation. The AA further stated that in cases of residents who suffer from delusions or hallucinations, and state falsehoods, the facility takes the situation at "total face value," however, would need to look at the pertinent information before deciding to report to the SA.

During interview on 3/31/15, at 3:56 p.m. AA

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F 225	Continued From page 34 stated when she receives notice of allegations of abuse, they determine if it is reportable and based on the information they decide whether to report to the SA or not. If she did decide the incident was reportable, she would do so immediately. During an interview on 03/31/2015, at 3:56 p.m. the director of nursing (DON) stated the facility's usual practice was for staff to immediately report suspected cases of mistreatment to the charge nurse. The DON further stated the charge nurse was then to determine possible cause, interview staff and residents. The DON stated the process of the facility was to determine if the cases were reportable so an immediate investigation needed to be completed in order to determine if the incident was reportable. The facility utilized a tool for determining injuries of unknown source. When asked about the facility's procedure for resident to resident altercations, the DON was unaware of any facility procedure for these cases though stated, " I would think that would also need to be reported immediately, however, would need to look it up." R49's allegation of mistreatment was not reported to the administrator and SA timely. In addition, when administration became aware of the allegation, an incomplete investigation was competed prior to reporting the allegation to the SA. R49's quarterly MDS dated 1/26/15, identified R49 had diagnoses that included dementia, anxiety, depression, seizure disorder or epilepsy, psychotic disorder. The MDS also identified R49 had severe cognitive impairment, and required	F 225		

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extensive assistance with all activities of daily living (ADLs) except for eating. The MDS also identified R49 had upper extremity impairment on one side.

R49's care plan dated 2/28/15, did not identify R49 had the potential vulnerability for abuse/mistreatment.

R49's last Vulnerability Assessment was completed on 10/31/13. The assessment identified R49 was mentally and physically unable to act in self-preservation.

During an interview on 03/30/15, at 6:12 p.m. FM-B stated, "I don't have proof, but this staff person's attitude was really bad, and I think she cut [R49's] fingernails too short out of anger." FM-B was able to describe the staff person and stated she had reported this incident to LPN-A and showed her R49's left hand and fingernails. She stated she told LPN-A about the angry staff person, and told LPN-A that the staff person had been angry right then. FM-B stated this staff person told R49, "You're taking a bath." She stated when R49 returned from her bath R49 was complaining "ow, ow," to her contracted left hand and R49 told FM-B that the staff person was rough. She stated she felt the staff person cut R49's nails on her contracted left hand intentionally to hide the injury as they did not trim R49's fingernails on the opposite hand which did not have a contracture.

On 03/31/15, at 3:56 p.m. the administrator and AA were interviewed regarding R49's allegation. An incident report was not found for the incident. On 4/1/15, at 10:05 a.m. the AA and DON provided a copy of the facility's investigation

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F 225	Continued From page 36 (started on 3/31/15, time unknown) regarding the allegation of mistreatment by R49. The AA stated they began their investigation last evening by interviewing staff regarding the incident. In regards to R49, the AA stated the NA had been identified and had been interviewed regarding the event. The NA had stated R49's finger nails were not cut any shorter than normal. The LPN identified as being informed of the event by R49's daughter had stated R49's nails had been observed to be no shorter than usual. The consensus of the AA and DON was that R49's daughter and was angry and perhaps was in a stage of the grieving process. Both the AA and DON verified no report to the SA had been completed, nor had R49 or a family member been interviewed regarding the allegation of mistreatment. R49's Incident/Vulnerable Adult Report & Investigation was submitted to Minnesota Department of Health (MDH)/Office of Health Facility Complaints (OHFC) at 12:00 p.m. on 4/1/15, after performing an internal investigation of the incident. R41's allegation of abuse/mistreatment from another resident was not reported to the administrator and SA timely. In addition, when administration became aware of the allegation, an incomplete investigation was conducted and then was not reported SA. During an interview on 3/31/15, at 9:17 a.m. R41 stated another resident hit her with a book repeatedly while they were in church. R41 stated she did report the incident to a staff member and was told by the staff member to just stay away	F 225		

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from the other resident. R41 could not recall the date and time of the incident.

R41's Admission Record identified diagnoses that included osteoarthritis and pain. The quarterly MDS dated 3/15/15, indicated R41 was cognitively intact, required supervision with transfers, and extensive assistance with locomotion on and off the unit.

The facility Vulnerable Adult Assessment dated 6/3/11, indicated R41 was at a low risk of vulnerability by others.

During an interview on 3/31/15, at 3:56 p.m. the administrator and AA were notified of the allegations of abuse/neglect/mistreatment regarding R41.

During an interview on 4/1/15, at 10:05 a.m. the AA and DON provided a copy of the facility's investigation (started on 3/31/15, time unknown) regarding the allegation of mistreatment by R41. The AA and DON provided a copy of the facility's investigation, regarding the allegation of resident to resident abuse. The investigation identified staff had been interviewed regarding the alleged event and no staff member had heard or witnessed the event. The AA then deemed the "potential personality conflict between the two residents." The AA had also presented information on two previous reports made by R41 which had been complaints of missing money, both of which R41 had retracted stating, "was kidding." Based on the investigation the AA and DON had determined the alleged event was deemed not reportable and likely had not occurred. The AA and DON verified R41 had not been interviewed regarding the event even

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F 225	Continued From page 38 though R41 was cognitively intact. The AA and DON verified no report had been made to the SA. The facility Vulnerable Adult Policy identified any employee in the facility who has reasonable cause to believe that a resident is being or has been maltreated, or has knowledge that a resident has sustained a physical injury is required to report such suspected maltreatment immediately to the administrator, facility designated reporter, department supervisor or charge nurse and also report to the Common Entry Point (CEP) and OHFC. The policy also identified the internal reporting procedures is to immediately make an oral report of the incident to the charge nurse. The facility Vulnerable Adult Policy dated 02/28/12, directed staff to promptly report suspected incidents of abuse, neglect, financial exploitation and maltreatment in the facility, immediately not to exceed 24 hours. The policy further directed the designated staff to review, investigate and if necessary, report the incident. The policy explained that investigation was often necessary to determine if the incident should be reported. The policy explained the internal reporting procedure was to be followed to ensure reporting of only those incidents which agree required to report. The reporting procedure was then defined as immediately making an oral report to the nurse in charge. The facility's procedure directed the charge nurse to complete an incident report as soon as possible, but no longer then before leaving work for the day. The incident report should not only define what happened also explain the investigation completed, findings and action taken. The charge nurse was then to turn in the incident report to the	F 225		

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F 225	Continued From page 39 designated reporter of the facility. The designee was then to investigate the incident which included interviewing the resident/staff, family, looking into environmental findings/factors, medical condition and diagnoses of the patient and making a determination of how the injury/incident occurred or may have occurred. Then following the investigation the designee was then to determine if a report needed to be made.	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement an abuse prohibition policy which required immediate notification to the State agency (SA) of any allegations of abuse, neglect, mistreatment prior to conducting an investigation. The facility failed to report allegations of abuse, neglect or mistreatment timely to the SA and failed to conduct through investigations for 6 of 6 residents (R49, R39, R58, R33, R49, R41) reviewed for potential allegations for abuse, neglect or mistreatment. This practice has the potential to affect all 31 residents residing in the facility. Findings include: The facility's Vulnerable Adult Policy incorrectly	F 226	It is the policy and the procedure that all alleged violations involving mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of resident property are immediately reported to the Administrator and other officials in accordance with state law. Resident# 33- Resident has expired. Resident #39-Resident has been discharged. Resident #41-A report was made to the state agency on 04/02/15. The report came back from OHFC AS non-substantiated on 04/09/15. Follow-up was done with resident and family. Care plan was reviewed and revised to include that resident at times may make offensive	5/18/15

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F 226	Continued From page 40 directed staff to conduct an investigation of any allegations PRIOR to reporting to the SA. The facility's Vulnerable Adult Policy dated 2/28/12, directed staff to promptly report suspected incidents of abuse, neglect, financial exploitation and maltreatment in the facility, immediately not to exceed 24 hours. The policy further directed the designated staff to review, investigate and if necessary, report the incident. The policy explained that investigation was often necessary to determine if the incident should be reported. The policy explained the internal reporting procedure was to be followed to ensure reporting of only those incidents which agree required to report. The reporting procedure was then defined as immediately making an oral report to the nurse in charge. The facility's procedure directed the charge nurse to complete an incident report as soon as possible, but no longer then before leaving work for the day. The incident report should not only define what happened also explain the investigation completed, findings and action taken. The charge nurse was then to turn in the incident report to the designated reporter of the facility. The designee was then to investigate the incident which included interviewing the resident/staff, family, looking into environmental findings/factors, medical condition and diagnoses of the patient and making a determination of how the injury/incident occurred or may have occurred. Then following the investigation the designee was then to determine if a report needed to be made. During an interview on 3/31/15, at 3:56 p.m. the director of nursing (DON) stated the facility's usual practice was for staff to immediately report suspected cases of abuse/mistreatment to the	F 226	statement towards others. Resident #49 □ A report was made to the state agency on 04/02/15. The report came back from OHFC as non-substantiated 04/09/15. Follow-up was done with resident and family. Care plan was reviewed and revised by interdisciplinary team to include assist of two with bathing as needed. Resident #58- Resident has been discharged. The facility policy on Abuse reporting has been reviewed and revised to include immediate reporting to Administrator, state agency and Common Entry Point of any mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of resident property, resident to resident altercation, and significant medication errors. Residents will be monitored for mistreatment, neglect, abuse, including injuries of unknown source and misappropriation of resident property, resident to resident altercations, and significant medication errors through shift to shift report, daily with cares and with interdisciplinary team meetings. All reports will be investigated and root-cause analysis performed. Medication Error form was updated to include an investigation and root cause analysis. Ongoing one on one education regarding reporting has been performed. Staff will have formal education on 5/6 and 5/07/15 on abuse prohibition and immediate reporting procedures as well as investigative techniques. Random audits are performed alternating	

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F 226	Continued From page 41 charge nurse. The DON further stated the charge nurse was then to determine possible cause, interview staff and residents. The DON stated the process of the facility was to determine whether the allegations were reportable so first an immediate investigation needed to be completed in order to determine if the incident was reportable. The facility utilized a tool for determining injuries of unknown source. When asked about the facility's procedure for resident to resident altercations, the DON was unaware of any facility procedure for these cases though stated, " I would think that would also need to be reported immediately, however would need to look it up." During an interview on 3/31/15, at 3:56 p.m. the assistant administrator (AA) stated when she receives notice of allegations of abuse, the staff determine if it is reportable first and based on the information they decide whether to report to the SA or not. AA stated if she did decide the incident was reportable, she would do so immediately. R49's significant medication error was not immediately reported to the SA as neglect of care, nor was a thorough investigation completed. R49's Diagnosis Report dated 4/3/15, identified R49 had diagnoses of diabetes, dementia, and explosive personality disorder and hypertension. R49's November, 2014, Medication Administration Record (MAR) revealed R49 had been receiving the following medications: -Keppra (anti- seizure), 250 milligrams (mg) by mouth twice daily for seizures, - metoprolol tartate (an anti-hypertensive) 12.5 mg by mouth twice daily for hypertension - Trazodone (an anti-depressant) 50 mg by mouth twice daily for anxiety, depression and mood	F 226	shifts daily by reviewing occurrence reports, shift report and 24 hour board for potential indicators of abuse, neglect, maltreatment and for injuries of unknown origin. All occurrences are reviewed at IDT meeting. Audits will be reviewed at facility QAPI meeting for trends and patterns. Administrator/designee is responsible for overall compliance.	

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F 226	Continued From page 42 disorder - melatonin (supplement used for sleep) 3 mg by mouth before bed for insomnia -Tylenol 1,000 mg by mouth before bed for degenerative joint disease A facility Medication Incident Report dated 11/8/14, revealed R49 had received another resident's (R33) medications at 5:15 p.m. The Incident Report further revealed R49 had incorrectly received the following medications: -Seroquel (an antipsychotic medication)12.5 mg by mouth - Lasix (a diuretic) 20 mg by mouth - Propranolol (anti-hypertensive) 20 mg by mouth The facility's Medication Incident Report dated 11/8/14, further revealed the cause of the error had been distraction and failure to identify the resident prior to administering the medication. The report also revealed the nurse had been counseled regarding rules of medication pass. The Incident Report identified the common entry point (CEP) was not notified as R49 had no injury. The Incident Report lacked any indication of SA notification of the significant medication error. R39's significant medication error was not immediately reported to the SA as neglect of care, nor was a thorough investigation completed. R39' Diagnosis List dated 4/3/15, identified R39 had diagnoses of diabetes, chronic kidney disease, and long term use of insulin and edema. Review of R39's January 2015, MAR and physician orders revealed R39 was receiving the following medications : -Novolog insulin sliding scale based on blood sugars checked before all meals and before bed - Novolin insulin 37 units in the morning and 30 units in the evening -Levaquin (antibiotic) 750 mg one tablet by mouth	F 226		

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F 226	Continued From page 43 -Prednisone (oral steroid) 10 mg (take 2 tabs) by mouth -Plavix (an anti-platelet) 75 mg by mouth -Synthroid (used for hypothyroidism) 88 micrograms (mcg) -Claritin (allergy) 10 mg by mouth -Toprol (anti-hypertensive) 50 mg by mouth -Lisinopril (anti-hypertensive) 2.5 mg by mouth -Lasix 80 mg by mouth - Zocor (cholesterol lowering) 40 mg by mouth A facility Medication Incident Report dated 1/31/15, revealed R39 had received another resident's (R58) medications at 4:35 p.m. The Incident Report further revealed R39 had incorrectly received the following medications: -Metformin XR (oral hypoglycemic agent) 1000 mg -Glipizide (oral hypoglycemic agent) 5 mg -Neurontin (medication used for neuropathy pain) 600 mg A multivitamin and fish oil. The 1/31/15, Incident Report further revealed the cause of the medication error was distraction and the nurse had failed to identify the resident prior to administration. The Incident Report lacked indication of SA notification regarding the significant medication error. R58's significant medication error was not immediately reported to the SA as neglect of care, nor was a thorough investigation completed. R58's Diagnosis List dated 4/3/15, identified R58's diagnoses of cardiac murmur, hypertension, diabetes and urinary incontinence. Review of R58's January 2015, MAR and physician orders revealed R58 received the following medications: -Metformin 1,000 mg by mouth -Lovenox (blood thinner) 40 mg injected daily	F 226		

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F 226	Continued From page 44 -nicotine patch 21 mg/24 hr daily topically -Prilosec (anti-reflux) 20 mg by mouth daily -Flomax (used for enlarged prostate) 0.4 mg by mouth -aspirin 81 mg by mouth -Centrum silver (multivitamin) one tablet by mouth -Lisinopril (antihypertensive) 10 mg by mouth -Lutein (eye vitamin) 20 mg by mouth -Albuterol/ipratropium nebulizers (used for breathing problems) nebulizer solution three times a day A facility Medication Incident Report dated 1/26/15, revealed R58 had received another resident's (R33) medications. The Incident Report identified R58 had received Lasix (diuretic) 80 mg by mouth. The Incident Report identified the cause of the medication error to be distraction. The staff member was instructed to identify patient before giving medication. The Incident Report also lacked indication of SA notification as well as physician response to the medication error. On 4/7/15, at 12:01 p.m. the medical director stated he would consider a significant medication error to be one that caused harm or could potentially cause harm to the patient. He confirmed that R39, R58 and R49's medication errors could all have been potentially significant. A policy was requested regarding the reporting of significant or potentially significant medication errors, but was not provided. R33 sustained two injuries of unknown origin (defined as a source of injury which was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury or the number of injuries observed at one point in time	F 226		

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F 226	Continued From page 45 or the incidence of injury over time) which were not reported to the SA immediately, and lacked a thorough investigation to determine if abuse/neglect or mistreatment occurred. R33's Diagnosis List identified diagnoses which included dementia. R33's quarterly MDS dated 1/27/15, identified R33 had severe cognitive impairment, and behavior symptoms of physical and verbal actions towards others as well as rejection of cares. The MDS also identified R33 needed extensive assistance of facility staff with all activities of daily living. R33's care plan dated reviewed on 2/15/15, identified R33 had severe cognitive impairment, short and long term memory deficit, moderately impaired decision making skills, poor safety awareness, was not safe and had physically declined requiring more staff assist. R33 was also identified as having "delusions" of staff going in the resident's room at night. The facility's Vulnerable Adult Assessment dated 2/16/10, indicated R33 was a low risk of vulnerability due to minor forgetfulness, minimal supervision needed for self preservation and an indication R33 was at the facility for short term placement. The facility was unable to provide a more recent vulnerability assessment which would reflect R33's cognition and assistance requirements and vulnerability risk at the time of the incidents. On 9/10/14, R33 was discovered to have bruising of unknown origin measuring 6 centimeters (cm) by 2 cm on the left inner thumb. R33 was unable to recall how the injury occurred. The facility did not report the bruise to the SA. On 9/12/14, a	F 226		

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F 226	Continued From page 46 note was made on the incident report for R33's bruise which indicated R33 was combative with cares on the evening of 9/9/14, had been swinging her hands and likely bruised thumb at that time, no neglect or mistreatment was suspected. A secondary form dated 9/10/14, titled, "Incidents of Unknown Origin Investigative Tool" identified no need to report to the SA as could assume that R33 slammed hand in drawer. The form further indicated the staff member did not observe bruising on R33 on 9/9/14. The investigation was incomplete and failed to rule out possible abuse/mistreatment. On 12/3/14, at 4:00 p.m. R33 was found to have multiple bruises on both lower arms which were not noted the night before by the staff member completing the form. The form lacked the number and the measurements of the bruises found on R33. A nursing progress note dated 12/3/14, at 11:58 p.m. indicated the nurse had been notified of R33's multiple bruises on her bilateral upper extremities. R33 was unable to state how the bruises happened. The "Incident of Unknown Origin Investigative Tool" staff interview section revealed the following statements: On 12/3/14, 4:00 p.m. R33's bruise was not noticed the day before and the staff did not know what happened. On 12/4/14, 6:50 a.m. no direct care was provided to R33 by the staff member nor was any new bruising noted with medication administration. On 12/4/14, 12:30 p.m. no bruising had been noted on previous shift on 12/3/14. On 12/4/14, R33's bruises had not been observed by staff prior to R33's bath, staff member didn't think it was out of the ordinary. A summary of the investigation indicated R33	F 226		

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F 226	Continued From page 47	F 226		

bruised easily and liked to layer clothing. Although the bruising remained an injury of unknown origin, there was no further investigation and the injuries were not reported to the SA.

On 4/1/15, at 10:12 a.m. the AA stated R33 could have easily bruised the left thumb while rummaging in drawers, or by picking up a six pack of bottled soda. R33 was a very busy person. The AA also stated she reviewed progress notes, interviewed staff and looked at medical conditions and/or diagnoses of a resident to determine the cause of an injury of unknown origin prior to reporting the incident to the SA to "see if it's reportable." The AA further stated the decision making tree for reporting injuries of unknown source was used to determine whether R33's bruising should be reported to the SA, and did not feel the bruising needed to be reported based upon her investigation. The AA further stated that in cases of residents who suffer from delusions or hallucinations, and state falsehoods, the facility takes the situation at "total face value," however, would need to look at the pertinent information before deciding to report to the SA.

R49's allegation of mistreatment was not reported to the administrator and SA timely. In addition, when administration became aware of the allegation, an incomplete investigation was competed prior to reporting the allegation to the SA.

R49's quarterly MDS dated 1/26/15, identified R49 had diagnoses that included dementia, anxiety, depression, seizure disorder or epilepsy, psychotic disorder. The MDS also identified R49

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F 226	Continued From page 48	F 226		

had severe cognitive impairment, and required extensive assistance with all activities of daily living (ADLs) except for eating. The MDS also identified R49 had upper extremity impairment on one side.

R49's care plan dated 2/28/15, did not identify R49 had the potential vulnerability for abuse/mistreatment.

R49's last Vulnerability Assessment was completed on 10/31/13. The assessment identified R49 was mentally and physically unable to act in self-preservation.

During an interview on 03/30/15, at 6:12 p.m. FM-B stated, "I don't have proof, but this staff person's attitude was really bad, and I think she cut [R49's] fingernails too short out of anger." FM-B was able to describe the staff person and stated she had reported this incident to LPN-A and showed her R49's left hand and fingernails. She stated she'd told LPN-A about the angry staff person, and told LPN-A that the staff person was angry right then. FM-B stated the staff person told R49, "You're taking a bath." She stated when R49 returned from her bath R49 was complaining "ow, ow," to her contracted left hand and R49 told FM-B that the staff person was rough. She stated she felt the staff person cut R49's nails on her contracted left hand intentionally to hide the injury as they did not trim R49's fingernails on the opposite hand which did not have a contracture.

On 03/31/15, at 3:56 p.m. the administrator and AA were interviewed regarding R49's allegation. An incident report was not found for the incident. On 4/1/15, at 10:05 a.m. the AA and DON provided a copy of the facility's investigation

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F 226	Continued From page 49 (started on 3/31/15, time unknown) regarding the allegation of mistreatment by R49. The AA stated they began their investigation last evening by interviewing staff regarding the incident. In regards to R49, the AA stated the NA had been identified and had been interviewed regarding the event. The NA had stated R49's finger nails were not cut any shorter than normal. The LPN identified as being informed of the event by R49's daughter stated R49's nails had been observed to be no shorter than usual. The consensus of the AA and DON was that R49's daughter and was angry and perhaps was in a stage of the grieving process. Both the AA and DON verified no report to the SA had been completed, nor had R49 or a family member been interviewed regarding the report of mistreatment. R49's Incident/Vulnerable Adult Report & Investigation was submitted to Minnesota Department of Health (MDH)/Office of Health Facility Complaints (OHFC) at 12:00 p.m. on 4/1/15, after performing an internal investigation of the incident. R41's allegation of abuse/mistreatment from another resident was not reported to the administrator and SA timely. In addition, when administration became aware of the allegation, an incomplete investigation was conducted and then was not reported SA. During an interview on 3/31/15, at 9:17 a.m. R41 stated another resident hit her with a book repeatedly while they were in church. R41 did	F 226		

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F 226	Continued From page 50	F 226		

report the incident to a staff member and was told by the staff member to just stay away from the other resident. R41 could not recall the date and time of the incident.

R41's Admission Record identified diagnoses that included osteoarthritis and pain. The quarterly MDS dated 3/15/15, indicated R41 was cognitively intact, required supervision with transfers, and extensive assistance with locomotion on and off the unit.

The facility Vulnerable Adult Assessment dated 6/3/11, indicated R41 was at a low risk of vulnerability by others.

During an interview on 3/31/15, at 3:56 p.m. the administrator and AA were notified of the allegations of abuse/neglect/mistreatment regarding R41.

During an interview on 4/1/15, at 10:05 a.m. the AA and DON provided a copy of the facility's investigation (started on 3/31/15, time unknown) regarding the allegation of mistreatment by R41. The AA and DON provided a copy of the facility's investigation, regarding the allegation of resident to resident abuse. The investigation identified staff had been interviewed regarding the alleged event and no staff member had heard or witnessed the event. The AA then deemed the "potential personality conflict between the two residents." The AA had also presented information on two previous reports made by R41 which had been complaints of missing money, both of which R41 had retracted stating, "was kidding." Based on the investigation the AA and DON the alleged event was deemed not reportable and likely had not occurred. The AA

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F 226	Continued From page 51 and DON verified R41 had not been interviewed regarding the event even though R41 was cognitively intact. The AA and DON verified no report had been made to the SA.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the failed to provide care and services in a a dignified manner for 2 of 2 residents (R49, R3) who were denied access to personal space and property and whose rights were restricted. Findings include: R3's facesheet dated 4/1/15, included diagnoses of subdural hemorrhage (bleeding in the brain), diabetes, hypertension (high blood pressure), depressive disorder, glaucoma, cataract, atrial fibrillation (irregular heart beat) convulsions(seizures), anxiety disorder, and history of falls. The quarterly Minimum Data Set (MDS) dated 3/2/15, indicated R3 was cognitively intact, had no behaviors and no mood symptoms. The MDS further indicated R3 required extensive assistance of one staff for transfers and ambulation, was unsteady but able to stabilize	F 241	It is the procedure of Lakeside Medical to promote care for residents in a manner and in an environment that maintains or enhances each resident□s dignity and respect in full recognition of his or her individuality. Resident #3 □ Resident was given access to her walker and it was left in her room. Her clothing was placed back in the closet and her personal alarms were removed. A negotiated risk agreement was discussed with resident and completed on 04/17/15.The negotiated risk form explains the risks versus benefits. Her care plan was reviewed and revised to include walker to be left in room, storing resident□s clothing in a dresser was removed and removed from the care plan the use of personal alarms. Resident□s Fairview case manager/NP had met with resident regarding an opportunity to return to her previous living environment in an assisted living facility. Resident	5/18/15

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F 241	Continued From page 52 without staff assistance, had no range of motion deficits, and used a walker and wheelchair. The care plan revised 3/17/15, for impaired mobility related to subdural hematoma. The goal was to be independent with mobility. The interventions include: R3 was to be independent with 4-wheeled walker for ambulation and independent with transfers from 8:00 a.m. to 3:00 p.m. From 3:00 p.m. to 8:00 a.m. R3 would use the wheelchair or be stand-by assist while walking with nursing staff. The care plan revised 2/15/15, for ADLs directed staff to provide contact guard assist while R3 picks out her clothes for the next day. All clothes from closet removed and placed in dresser drawers. The closet was not to be used at all. The care plan revised 9/3/14, for altered thought process indicated R3 was alert and oriented, voiced her needs and expressed her feeling effectively. Independent in her decision making. Safety awareness was poor and was alarmed for her safety. Incident reports were reviewed for R3's falls and R3 had 9 falls between the dates of 7/16/14 and 3/24/15. The facility initiated interventions to attempt to prevent falls including alarms on R3's wheelchair and bed, which alarm when she attempts to stand from her wheelchair or turns in bed. Further interventions included putting a dresser in front of R3's closet doors so she could not use her closet, and placed her clothes in the dresser drawers. R3's walker was removed from her room between the hours of 3:00 p.m. and 8:00 p.m. and locked up at the nurse's station. Documentation indicated R3 initially agreed to the	F 241	discharged from the facility 4/25/15. Resident #49- The door knob cover was removed from door on 4/16/2015 and the removal of the bathroom lock was completed during survey. Care plan has been reviewed and revised by interdisciplinary team to include removal of door knob cover. The lock on the bathroom door was not in use as an intervention for Resident #49. Family was provided education regarding removal of the door knob cover. During new employee orientation and annually staff will be educated on Resident Rights and treating residents with dignity. Resident Rights policy was reviewed and revised. Resident council reviewed the Resident Bill of Rights which included treating residents with dignity. Resident□s at resident council received copies of the resident rights and were provided education on 4/14/2015. Residents who did not attend the council meeting were met with either individually or in small groups between 04/14 and 04/20 and were given a copy of the bill of rights, and an acknowledgment was signed. A letter was written by Nursing Home Administrator and mailed to all responsible parties along with a copy of The Resident Bill of Rights. IDT was provided training on dignity by a licensed social worker May 4th, 2015. Staff will have education on dignity on 5/6 and 5/7/15. Audit for dignity which includes observation of if residents have access to their personal belongings, observation of them having access to	

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F 241	Continued From page 53 intervention regarding the restriction to her closet drawer and from her walker. R3 had expressed to staff that she did not want the alarms and frequently turned off the alarms. R3 also verbalized to staff that she did not want to be restricted from her closet or her walker. Following a fall on 7/16/15, the interdisciplinary team (IDT) including nursing, administration, physical therapy (PT), occupational therapy (OT), social services (SS) and the nurse practitioner (NP) agreed with the removal of clothing from the closet and placing it into drawers, and a dresser was placed in front of the closet. SS documented on 7/16/14 that R3 agreed to the night stand and dresser to block the doors to prevent R3 from opening the closet doors. Following a fall on 7/20/14, the IDT note dated 7/21/14 indicated staff placed an alarm on her wheelchair and limited her ability to transfer independently. Following a fall on 8/21/14, when R3 tripped on her walker, the walker was removed from her room. The progress note dated 8/23/14, at 3:06 p.m. indicated R3 was standing up in her room holding the alarm. She was also in the hallway with her alarm in her hands, and it was turned off. The IDT meeting note dated 10/7/14, R3 had stated, stated 'I don't care if I fall, I want to do what I want.' The incident follow-up indicated R3 lacked safety awareness and didn't understand consequences, and staff were to ensure alarms were out of her reach under the wheelchair. A care conference note dated 12/16/14, indicated R3 questioned the need for alarms and was reminded of her frequent falling. No changes were made at that time. A progress note dated 2/15/15, indicated R3 was	F 241	areas in their rooms, observation of staff interaction with residents have been completed 5x/week x 1 week, 3x/week x 2 weeks quarterly thereafter. Audits will be reviewed and facility QA&A committee. The Assistant Administrator is responsible for overall compliance.	

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F 241	Continued From page 54 crying and upset that someone took her walker out of her room without telling her. R3 was reminded that she could not use her walker without assistance due to safety. R3 was tearful that her walker was taken out of her room and stated she understood she needed assistance with her walker. It was explained that the removal of her walker was an order from PT. Progress notes indicated on 3/24/15, at 7:10 a.m. when R3 tripped over the wheel of her walker. The bed and seat alarms were replaced, the walker was removed from the room to allow for the area to be free of clutter, and R3 was encouraged to request assistance with tasks. R3 was tearful. R3 made statements, such as "People fall, I just tripped, I was doing so good." R3 was receiving PT at that time. The 24 hour follow-up on the incident report indicated R3 called for assistance during the night as instructed on 3/25/15 and 3/26/15. The IDT note on the incident report, indicated R3 stood up instead of using the wheelchair, so the intervention was to remove the walker from the room at 3:00 p.m. R3 was to go to the nurse's desk at 8:00 a.m. and it would be given to her for use. The IDT progress note dated 3/25/15, identified the root cause to be standing instead of using her wheelchair as previously agreed. The action was to remove the walker from the room between 3:00 p.m. and 8:00 a.m. A progress note dated 3/25/15, at 7:07 a.m. indicated R3 continued to turn off alarms and self transfer. When reminded to call for help she states, "But I don't want to wait." The Physical Therapy Discharge Summary dated 4/7/15, indicated R3 was independent with gait and 4 wheeled walker from the hours of 8:00 a.m.	F 241		

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F 241	Continued From page 55 to 3:00 p.m. From 3:00 p.m. to 8:00 a.m. R3 used her wheelchair for locomotion and stand by assist for all transfers due to history of increased falls during this time range. "Pt is in agreeance (sic) with this schedule." the Tinetti (balance test) score is 24/28 which indicated a medium fall risk. The Quarterly Psychotropic Medication monitoring tool dated 12/4/14, indicated R3 was cognitively intact. A physician progress note dated 7/3/14, indicated R3 was alert and oriented with her memory and judgement intact. R3 was wearing a personal alarm in her wheelchair as she still required assistance with transfers. The MD progress note dated 1/8/15, indicated R3's insight, judgement and memory were intact. The NP progress note dated 3/19/15, indicated R3's cognition remained at baseline, with no behaviors. R3 did report feeling a little more depressed, and the NP indicated that "may be from the edema." R3's medical record was silent regarding a risk/benefit or informed consent pertaining to restrictions from her closet, restricted use of her walker, and the alarms in her bed and wheelchair. On 3/31/15, at 2:59 p.m., R3 was observed in her wheelchair in the hallway. An alarm and auto-lock brakes were on her wheelchair. During an observation on 4/1/15, at 7:31 a.m. R3's bed had an alarm hanging on it, bilateral upper grab bars were in place, and there was a dresser in front of the closet with a sign on the closet door indicating the clothes were in the dresser. The closet doors were completely obstructed. There were signs in the bathroom with a reminder to use the call light.	F 241		

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	245374	A. BUILDING _____ B. WING _____	04/08/2015

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F 241	Continued From page 56 During an observation on 4/1/15, at 7:36 a.m. R3 was propelling her wheelchair from the dining room, using her feet. An alarm was hanging on the back of the wheelchair and auto-lock brakes were on the wheelchair. During an interview on 4/1/15, at 9:09 a.m. R3 stated the staff put the dresser in front of her closet doors because she fell twice getting things out the closet. R3 stated she doesn't like it and feels like she is getting "punished." R3 stated she would like to be able to use her closet. R3 stated she fell a couple of weeks ago, and tripped over her 4-wheeled walker, so they took away her walker from 3:00 p.m. to 8:00 a.m. R3 stated she asked them, "What if I trip over my bed, will you take away my bed? What if you (staff) fall, what will they take away from you?" R3 said she joked about it but the restrictions don't make her feel very good. R3 stated each time they restrict her, she feels like she is being punished. R3 stated she has said that to the nurses and the director of nursing (DON) replied that she is not being punished, but that it is for her safety. R3 reported she has asked them to take the alarms off and they continued to tell her in a couple of weeks, but then they said a couple of months, and when she reached 2 months, she fell again. R3 stated she did hit her head each time, so they kept telling her it was for her safety. R3 repeated the staff put her walker in the office at 3:00 p.m. and she has to go down at 8:00 a.m. and ask for it back. R3 stated she was getting PT and will be done with that soon, and thinks they will give her walker back. R3 stated she falls because of legal blindness in one eye related to glaucoma and a cataract in the other eye. R3 has asked PT and the eye doctor if her eyes could cause her to lose her balance and was told that it could. R3 stated	F 241		

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she did not feel dizzy before she falls, but said her blood pressure is high and adjustments in her medications have not helped. R3 stated the restrictions were affecting her depression and that she feels like she was "in prison." R3 spoke in a stuttering and halted speech pattern, and stuttered more when she spoke of her restrictions and how they made her feel. R3's voice broke at one point, and she had a sad facial expression throughout the interview.

During an interview on 4/1/15, at 2:36 p.m. R3 stated she cannot get into her closet and wanted to be able to hang some of her clothes in the closet. R3 stated her clothes are in different drawers around the room, and the drawers are too full so the clothes were wrinkled. R3 stated she does not like to wear wrinkled clothes. R3 stated she feels better when her clothes are not wrinkled. R3 talked about not having her walker and said she had to go down to the desk and get it every time. R3 said she wanted it in her room as it was an effort to bring it down to the desk and go get it in the morning. She further emphasized it was her walker and she wanted it in her room. R3 stated when she used the walker, it was the only time she had any independence. When she didn't have the walker, she used the wheelchair. R3 stated it was easier to get around with the wheelchair, but wanted to maintain her independence. Additionally, she wanted to decide when she used the walker, not have staff decide. R3 further clarified she felt like she was punished and in prison because she lost some of her freedoms. R3 stated she felt more secure when the walker was in her room, because it's hers. R3 further described how she felt when she was restricted from her walker and her closet, by saying she has a loss of pleasure and felt more

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agitated when they took the walker away. R3 stated she still felt agitated. R3 described agitated as being more tied down, and said the alarms added to that feeling. She said that in a way, she felt worthless and not like a normal person because she didn't have the freedom she would like to have. R3 stated that not having the choice of using the walker, not getting into her closet, and the alarms, made her feel like she didn't have the same rights as a normal person. R3 stated she has asked about the alarms and has told the staff she doesn't like them. R3 stated she agreed to the restrictions of the closet and the walker because she felt she did not have a choice, and felt disappointed and restricted. Re stated she felt like she gave up and there was nothing she could do about it.

During an interview on 4/2/15, at 4:45 p.m. the social services designee (SSD)-A stated they promote resident participation in the care planning process by asking them specific questions about how staff treat them and preferences, such as bed times, bathing, and clothes. SSD-A stated when residents have a change in their daily life and care, they have a care conference. SSD-A stated she visited with R3 many times and said at times, R3 is very copasetic about her restrictions. When asked about the restrictions R3 has and their impact on R3's rights, SSD-A stated of course they impinge on her rights. When asked if the restrictions impacted R3's dignity, SSD-A stated, "Yes, absolutely." SSD-A stated it is a safety issue.

During an interview on 4/3/15, at 9:29 a.m. nursing assistant (NA)-E stated they monitor R3 in the morning and her walker is in the medication room. NA-E stated R3 will say "If I trip over my

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F 241	Continued From page 59 bed, will you take it away? If you fall, what do they take away from you?" NA-E stated R3 is able to make decisions about her daily care and that other decisions are reasonable. During an interview on 4/3/15, at 9:36 a.m. the licensed practical nurse (LPN)-F stated R3 got to use her walker between 8:00 a.m. and 3:00 p.m., as therapy said she could be independent during those times. LPN-F stated R3 responded well when it was explained to her, but has shown frustration with needing more assistance. LPN-F denied R3 has reported anything about not getting into her closet. During an observation and interview on 4/6/15, at 8:52 p.m. she had to bring her walker down to the desk at 3:00 p.m., but just didn't do it. R3 stated that when they take her walker to the desk she feels disappointed. R3 stated she felt " like I'm a naughty child and they are taking my toys away." R3 stated she was feeling lonely when I came here, but felt innocent then because she hadn't done anything wrong. During an interview on 4/7/15, at 9:24 a.m. with the director of nursing (DON) and the assistant administrator (AA), they stated R3 had fallen after using the closet. They stated the dresser space gave her more space than her closet provided. When told how R3 was feeling, the DON stated that was not the intent, but that it was for her safety. The facility policy and procedure for resident's Bill of Rights for Medicare and Medicaid certified nursing facilities, reviewed 3/4/15 indicated residents have the right to participate in the planning of their health care, including the	F 241		

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F 241	Continued From page 60 opportunity to discuss treatment and alternatives with individual caregivers. The policy and procedure further directed competent residents shall have the right to refuse treatment, medication or dietary restrictions and will be informed of the likely medical or major psychological result of the refusal, with documentation in the medical record. The facility was unable to provide a policy and procedure for dignity and choices. R49's quarterly MDS dated 1/26/15, identified R49 had diagnoses that included dementia, anxiety, depression, seizure disorder or epilepsy, and psychotic disorder. The MDS also identified R49 had severe cognitive impairment, and required extensive assistance with all activities of daily living (ADLs) except for eating. R49's care plan dated 2/28/15, identified R49's room door was to be closed when resident was out of her room to discourage her from going into her room alone. The care plan also identified that the door knob cover was applied to her door knob to deter R49 from entering her room alone for her safety. The care plan also identified R49 will participate in independent activities of choice, has a TV in her room, and has a goal to improve ADLs and self-care ability. On 3/30/15, at 5:17 p.m. observed bathroom lock on the top of R49's bathroom door out of R49's reach. The lock was secured and locked to prevent R49 from getting in. During an observation on 4/1/15, at 10:11 a.m. a large, white plastic child-proof door knob cover was applied to the outside of R49's bedroom door, visible to the public in a high traffic hallway. R49 was outside her bedroom door struggling to	F 241		

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open the door to her bedroom. After several failed attempts, R49 gave up and began to self-propel down the hallway very slowly, grabbing on to rails to pull herself along the distance of the hallway.

During an observation on 4/1/15, at 10:20 a.m. R49 returned to her bedroom door and tried to enter again. R49's bedroom door was closed, with the child proof door-knob covering on the door knob to prevent R49 from getting into her room. R49 continued to try to turn the door knob to get in to her room. After R49 could not get into her room, she started to call out "help, help, help" and kicked her bedroom door in frustration. The physical therapist (PT)-A who was walking down the main hallway quickly took R49 away from the front of her bedroom door, and pushed R49 down the hallway and stated, "Let's follow everyone down here." PT-A pushed R49 down to the dining room and left the area.

During an observation on 4/2/15, at 2:25 p.m. there was a bathroom lock on the top of R49's bathroom door out of R49's reach. The lock was secured and prevented R49 from getting in.

During an interview on 3/30/15, at 6:56 p.m. R49's family member (FM)-B was interviewed. FM-B stated she has met with the nurse practitioner (NP), various nurses, and DON regarding her concerns about the lock on the bathroom door and the plastic door knob cover on the outside of her bedroom door. She stated, "I did not like that she was restricted from her room, and the door knob cover prevents [R49] from opening the door and entering her room."

During an interview on 4/2/15, at 9:42 a.m. social services designee (SSD)-A stated the door knob

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F 241	Continued From page 62 and bathroom lock was to keep her safe. SSD-A stated, "Knowing [R49], it was probably the last thing the interdisciplinary team came up with." SSD-A stated, "[R49] is allowed to go into her room in the afternoon for a nap." SSD-A was asked if other interventions other than the child-proof door knob and bathroom lock were considered, and what her opinions were regarding the child-proof door knob and bathroom lock. SSD-A smiled and stated, "I know you're gonna quote me," and did not answer the questions. SSD-A then stated, "I understand your point about the dignity and privacy of the external door knob and the bathroom lock." SSD-A added, "The bathroom door lock has nothing to do with [R49], it is still there from years ago." SSD-A stated the child proof door knob was on R49's care plan. During an interview on 4/2/15, at 2:00 p.m. activities aide (A)-A stated she knew R49 well and she had worked at the facility for over three years. A-A stated R49 was not allowed to go into her room alone, and she has a safety handle on her door knob so she can't go into her room. A-A stated R49's bathroom lock could be used to keep R49 out. A-A added. "I've seen her try to get in with the safety door knob on, and will call out when she can't get in." A-A stated, "Having the child proof door knob on her door is troubling for [R49] as it would be for anyone knowing that is your room and you can't go in." A-A stated they receive resident rights training annually and on hire. A-A stated that this could be not be following the resident rights. During an interview on 4/02/15, 2:27 p.m. NA-A stated R49 tries to get into her room and kicks the door when she can't get in. NA-A stated R49	F 241		

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does her normal yelling out "help " when she can't get into her room. NA-A stated, "We usually try to detour her when we see her trying to get into her room." NA-A confirmed the bathroom was locked and stated, "The bathroom lock is to keep her out of there because she has tried to self-transfer." NA-A added. "[R49] has always been a very independent person, I would think it is discouraging to her when she can't go into her room."

On 4/2/15, at 2:30 p.m. NA-C reviewed R49's NA care sheet, and quoted the document reading,"The reasoning for [R49's] door knob is to keep R49 out of her room."

On 04/02/15, at 4:43 p.m. SSD-A stated she received some training from the previous social worker on some resident rights and stated, "The previous social worker kind of trained me on resident advocacy." She added she has been the SSD for 3 years. SSD-A stated the bathroom door lock is from a previous resident. SSD-A stated she definitely agrees that the knob is a dignity issue, as people can see her name on the door and the child proof door knob.

On 04/03/15, at 8:45 a.m. registered nurse (RN)-B stated the bathroom door lock should be care planned. RN-B stated she thought it was, but couldn't guarantee it. RN-B stated the child proof knob reminds R49 that she can't go in to her room, and R49 calls out when she can't get into her room. RN-B stated, "She [R49] doesn't listen, she is a very independent lady, [R49] is used to getting what she wants, and doing what she wants." RN-B stated R49 knows which room is hers, and might go into other resident rooms because she can't get into her own room. RN-B

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F 241	Continued From page 64 stated R49 has told her "they are trying to keep me out of my room." RN-B stated R49 can be in her room before she gets up in the morning, for toileting, her afternoon nap and when she has visitors. RN-B stated, "There has been times when [R49] can't get into her room and she calls out, and then they keep her out in the hallway." RN-B added R49 has no access to her room when she is confused or calling out "help me." RN-B stated she felt this was a dignity issue. On 4/3/15 9:51 a.m. the director of nursing (DON) stated, they would tell R49, "We have to keep the door closed to keep you out here with us." The DON stated R49 would wiggle and play with her doorknob and she has seen/heard her call out "help" when she couldn't get into her room. She stated, "I get your concern with dignity." The DON stated, "What we need to do now is discuss concerns with IDT and decide if this is a dignity issue, as a team we are looking at the infringement of [R49's] rights to get into her room to get at her things." On 4/3/15, at 11:56 a.m. R49 stated, "The door knob bothers me" and "I feel locked out of my room." R49 added, "I have to stay out of my room until it gets opened, I have to sneak in and whenever they don't lock the door I go in." R49 stated, "I yell at staff when I can't get into my room, I told them I don't like it, they should take the knob off so I can get into my room when I want to, I rent the room so they shouldn't keep me out." According to "Your rights Under The Combined Federal and Minnesota Residents Bill of Rights," MDH, 7/1/07, identified the facility violated R49's rights to dignity, self-determination and	F 241		

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F 241	Continued From page 65 participation, and personal property. The right to dignity is to care for you in a manner and environment that maintains or enhances your dignity and respect in full recognition of your individuality. The right to self-determination and participation to make choices about aspects of your life in the facility that is significant to you. The right to personal property is you have the right to retain and use personal possessions including some furnishings, and appropriate clothing.	F 241		
F 244 SS=F	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide residents the opportunity to voice grievances about their care or life in the facility during the resident council meetings for 1 of 1 resident (R3) reviewed for grievances. This had the potential to affect all 31 residents residing in the facility. Findings include: R3's quarterly Minimum Data Set (MDS) dated 3/2/15, indicated R3 had no cognitive impairment, no signs or symptoms of depression and no behaviors that were distressing or disruptive to	F 244	It is the practice of Lakeside Medical to listen and act upon the grievances and recommendations of residents and families. Resident #3- has been discharged to an assisted living facility. The policy and procedure for grievances has been reviewed and revised to include all grievances brought forward at resident council that cannot be resolved during the meeting will be logged and reported to the appropriate person for resolution. The person or persons lodging the grievance will be notified of the resolution within 7	5/18/15

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F 244	Continued From page 66 the resident or the facility. R3 was interviewed on 4/6/15, at 4:02 p.m. regarding the resident council. R3 indicated that the last time she went to the resident council meeting she was telling them about her personal concern and the director of nursing (DON) told her not to talk about that here, that they were there to have staff say what is on their mind. R3 stated, "All we hear is that its' a new rule. That's it. You have to abide by that." R3 concluded by saying the resident council is all about what they (facility staff) want to say and doesn't give the resident a chance to say what they want. Review of the Resident Council Meeting minutes dated 8/19/14, 9/9/14, 10/14/14, 11/18/14, 12/9/24, 1/13/15, 2/10/15, and 3/10/15 revealed old and new business relating to activities. At the bottom of the minutes was the statement, "All concerns from prior month have been resolved." In addition, R3 was listed as attending each of these meetings. During an interview on 4/6/15, at 12:16 p.m. the social service designee (SSD)-A stated she attends the resident council meetings on occasion. She stated that activities is "pretty much" the focus of the meetings: special meals, music, etc. Residents do bring up concerns, but she had no specific examples. During an interview on 4/8/15, at 1:30 p.m. the activities director (AD) stated any concerns raised at the resident council meeting are given to the appropriate department head. She makes some notes, does not record them in the minutes and after letting a department know about a concern (food, for example, to dietary), she puts her notes	F 244	days and the response to the grievance(s) will be reported to the council at the next meeting. The completed grievance forms from resident council will be kept in the resident council minute book. The DON was not as the resident council meeting as indicated in the MDH statement of deficiencies. Resident council was provided education and a copy of the revised grievance procedure on 04/14/15. A letter was written by the Nursing Home Administrator and mailed to all responsible parties along with the Complaint/grievance policy and procedure. A log will be used to track any written grievance or concern. Staff will be provided education on 5/6 and 5/7 on the grievance policy and procedure. Random audits via staff interview will be performed weekly x 3 weeks in regards to the grievance policy and random resident interviews will be completed regarding follow up on their concerns. Audits will be reviewed at facility QAPI meeting. Administrator/designee is responsible for overall compliance.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 244	Continued From page 67 in the shredding receptacle. The AD stated that she has been in her position for 3 years and they have not had any concerns in that time about rules of the facility or resident rights. During a follow-up interview with the SSD-A on 4/8/15, at 1:19 p.m. she stated she did not have any grievances on file, and that she gets copies but had just cleaned out her file. During an interview on 4/8/15, at 1:54 p.m. the administrative assistant (AA) indicated there have been no grievances filed with the facility in the last several years.	F 244		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 water temperatures were monitored and were at a safe temperature for 11 of 11 residents residing in the CD hallway of the facility. Findings include: During environmental observations the evening of 3/30/15, the water temperature in the CD hallway	F 323	It is the policy of Lakeside Medical Center to ensure that the resident environment remains as free of accident hazards as possible. The policy for Hot Water Supply has been reviewed. Employee responsible for weekly temperature checks has been re-educated on policy. All rooms have been checked for appropriate water temperature. Environmental walk through	5/18/15

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F 323	Continued From page 68 bathrooms was found to be very hot to touch. On 3/30/15, at 7:30 p.m. the water temperatures in room 248 was checked with a thermometer and found to be 130.2 degrees Fahrenheit (F) and the water temperature in room 274 was found to be 130.4 degrees F. On 3/30/15, the assistant administrator (AA) was informed the water temperatures in the CD hallway were not at sefe levels. The AA stated environmental services would be notified, but that they had gone home for the day. During an interview on 3/31/15, at 8:36 a.m. the environmental services director (ESD) stated the water temperatures were checked and some of them had been turned down. On 3/31/15, at 10:06 a.m. the ESD provided the water temp log and policy and procedure for hot water supply. The facility water temp logs indicated water temperatures were not consistently monitored. The log indicated no resident rooms were checked on 11/12/14. One resident room (Room 266) was checked on 12/4/14, and was found to be 110 degrees. Two resident rooms were checked on 12/17/14, and were found to be 105 and 103 degrees. On 2/3/15, the water temperatures were checked in three resident rooms, and recorded at 99.9, 95, and 115 degrees F. The water temperature log indicated on 3/31/15, water temperatures in three resident rooms in the CD hallway were checked; room 225 (119 degrees), 270 (117 degrees), and 275 (119 degrees). The log indicated they were "a little high", and no action was taken. During environmental rounds on 4/2/15, at 2:30 p.m. with the ESD and the AA, water temperature was checked in room 248 and was found to be	F 323	survey has been updated to include checking of water temperature logs. Environmental Services Supervisor or her designee will conduct weekly audits until compliance is reached and quarterly thereafter or as needed. Results of such audits will be reviewed for compliance by facility QAPI Committee. Director of Environmental Services will be responsible for overall compliance.	

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F 323	Continued From page 69 110 degrees F. The water temperature in room 248 was 110 degrees F, room 249 was 110 degrees F, room 250 was 111 degrees F, room 251 was 111 degrees F, and room 274 was 109 degrees F. The ESD stated the water temperatures were to be checked weekly and if too high, they would adjust the temperature. The ESD stated there is one adjustment for all rooms in the CD hallway. The ESD verified the water temperatures had not been monitored routinely. The policy and procedure for hot water supply dated 8/7/14 indicated temps should not exceed 120 degrees. It further directed water will be tested at the north and south ends of the building once weekly or more often as needed.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically	F 329		5/18/15

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F 329	Continued From page 70 contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, document review the facility failed to ensure a resident was free from unnecessary medications for 1 of 5 residents (R6) reviewed for unnecessary medications. Findings include: R6's physician orders, printed 4/2/15, revealed R6 received Haldol 0.5 mg by mouth daily at 2:00 p.m. and evening for hallucinations related to psychosis, start/revised date of 3/19/15. The physician orders also revealed R6 was receiving Zoloft 50 mg daily by mouth for a diagnosis of depression, start/revised date of 3/19/15. R6's quarterly Minimum Data Set (MDS) dated 2/9/15, identified R6 had diagnoses of dementia, Parkinson's disease, depressive disorder and psychosis other than Schizophrenia. The MDS further identified R6 had severe cognitive impairment. R6's PHQ-9 (interview for depressive symptoms) revealed R6 had mood problems of feeling tired and having little energy 12-14 days (out of the 14 day assessment period), trouble with sleep either too little or too much, feeling down and depressed and feeling tired and having little energy. The MDS also revealed R6 had behaviors of rejection of cares and physical behaviors directed at others. On R6's previous	F 329	It is the policy and procedure of Lakeside Medical Center that residents are free from unnecessary drugs. Resident #6- Care plan was reviewed and revised by interdisciplinary team on 04/29 and 04/30. Resident expired on 04/30/2015. Psychotropic medication policy and procedure was reviewed and revised on 04/27/15 to include monitoring of behavior and again to include ruling out reversible conditions prior to the administration of a psychotropic medication unless resident is at risk for self harm or at risk of harming others. At the IDT meeting residents are reviewed for changes in mood or behavior. A behavior algorithm to rule out reversible causes of behavior is now available for staff to reference. Medication regimen reviews to identify potential irregularities are conducted monthly for all residents by the consultant pharmacist. During the monthly medication regimen review, the pharmacist evaluates resident-related information for dose, duration, continued need, appropriate monitoring, and the emergence of potential adverse consequences for all medications. Any potential irregularities identified are	

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F 329	Continued From page 71 quarterly MDS assessment dated 11/10/14, revealed no mood symptoms of depression or behaviors towards others. Review of R6's care plan revised 8/12/14, identified R6 received psychotropic medications. The care plan directed staff to observe for changes in mood, behavior and determine the cause. The care plan for altered thought process revised on 11/18/14, identified R6 had specific behaviors of paranoid thoughts, depression, withdrawn, yelling at other residents and thinking a male was her spouse. The care plan directed staff to provide re-orientation, gentle touch, assist with activities and visiting other residents, out of room activities, calm approach, providing distraction, separate from other residents if issues arise. The care plan directed staff to document behaviors and efficacy of interventions. The care plan was again revised on 11/20/14, identifying R6 had a specific behavior of thinking a male was her spouse and verbal abuse towards another resident. The care plan directed staff to implement interventions of; separation from male resident, assist to room, provide with calm conversation, reminisce about daughter and husband and show pictures of her husband. R6's care plan was again revised on 12/17/14, identifying R6 received Zoloft (antidepressant) and Haldol (antipsychotic) medications related to behavior management: depression and psychosis with hallucinations and delusions. R6 was to be free of drug related complications, and directed facility staff to attempt to provide distraction when R6 became agitated; offering food and drink, 1:1 visits, use of the dayroom and to keep within site of staff. The care plan further directed facility staff to monitor and record occurrences of the target	F 329	communicated to the attending physician. The Director of Nursing receives a monthly report from the Consultant Pharmacist in regards to irregularities found and assures and tracks MD response to recommendation. All medications are reviewed within the first month of initiation by the Consultant Pharmacist. Medications are reviewed quarterly with each resident care conference or sooner if a change of condition is noted. During the review, the interdisciplinary team evaluates mood, function, behavior, and other domains that may be affected by medications. Residents are monitored daily for behavior, mood, illness or cognitive changes which could indicate a change in condition. Discussion of changes in mood/behavior have been added to daily IDT meeting template. Staff educated on revised policies 05/05/15 and 05/06/15. Weekly audits will be completed on psychotropic medication use and initiation of psychotropic medication until compliance is reached then quarterly thereafter and results will be reviewed at facility QAPI meeting. Director of Nursing is responsible for overall compliance.	

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F 329	Continued From page 72 behaviors. The care plan did not direct facility staff to monitor effectiveness of non-pharmacological interventions. A facility form titled, Behavior Management Assessment, dated 2/9/15, identified R6 had behaviors of paranoid thoughts, depression, withdrawn, looking for family members and thinking a male resident was her spouse. The assessment identified R6 had behaviors of refusing cares, yelling out, and yelling at staff and other residents. R6 was also identified to get upset if a female resident spoke with the male resident R6 thought was her spouse. The assessment further identified R6 tried to hit and kick staff, leave the building and threatened to call the "cops." The summary revealed R6 was mostly pleasant and cooperative, visited with peers, enjoyed activities and to offer non-pharmacological interventions. Review of consultant pharmacist communication to physician/practitioner dated 2/24/15, revealed a note by the pharmacy consultant which identified R6 was started on Haldol 0.5 mg twice daily, started 12/17/14 for episodes of increased anxiety/delirium during the time R6 had a potential urinary tract infection. The note further revealed a lack of documentation in the nursing notes regarding ongoing problems of hallucinations or delusion. A facility form titled, Quarterly Psychoactive Medication Review revealed a note dated 3/10/15, which identified facility staff had discussed a gradual dose reduction (GDR) of the Haldol and no reduction was warranted at that time. The form lacked rationale for R6's continued need for the antipsychotic medication.	F 329		

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F 329	Continued From page 73 Review of progress notes from 12/15/14 to 4/2/15 revealed: 12/1514 - R6 was started on Cipro (antibiotic) for possible urinary tract infection (UTI), and was having nausea, vomiting and diarrhea. 12/17/14 - R6 was administered Haldol 2 mg intramuscularly for acute psychotic behavior of attempting to leave facility, a later note revealed R6's physician had ordered a urinalysis and scheduled Haldol medication management. 12/23/14 - follow up of antibiotic treatment revealed the antibiotic R6 had been taking for a possible UTI was resistant to the antibiotic, the nurse practitioner was notified. 12/29/14 - R6 was transferred to the hospital for respiratory symptoms, was hospitalized and returned on 12/31/14 and was placed on isolation precautions for influenza. 1/25/15 - the progress note revealed R6 was again not feeling well with respiratory symptoms, an antibiotic was ordered. 2/6/15 - the progress note revealed R6 had received the antibiotic for pneumonia and facility staff was to observe for further symptoms. 3/8/15 - R6 was noted to have respiratory symptoms with a fever. 3/10/15 - R6 was seen by nurse practitioner for an upper respiratory infection. 3/13/15 - R6 had behaviors towards male	F 329		

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F 329	Continued From page 74 resident, non-pharmacological interventions implemented of 1:1 time and talking about husband - R6's behavior subsided. 3/15/15 - R6 had behaviors towards a male resident - staff then implemented non-pharmacological interventions which were effective. 3/17/15 - the nurse practitioner addressed R6's change in health status and indicated R6 was most likely aspirating which resulted in multiple respiratory infections. R6's progress notes lacked any consistent documentation of behaviors following the routine administration of Haldol. In addition, staff did not address the potential of R6's multiple illnesses being a factor in the sporadic behaviors. Review of behavior monitor flowsheets for 2/15 and 3/15, lacked the identification of non-pharmacological interventions used for R6 and their efficacy. Review of a physician progress note updated 3/14/15, for an encounter on 3/10/15, revealed the certified nurse practitioner saw R6 for an upper respiratory infection. The note revealed an assessment of R6's cognition was at baseline and had a behavior of obsession with a male resident, though no other behaviors. The note further reveled R6 was doing well on the Haldol with decreased behaviors. The note lacked any assessment of R6's behaviors related to the multiple acute illnesses since 12/15/14. Observations of R6 on 4/1/15 revealed the following:	F 329		

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F 329	Continued From page 75 7:06 a.m. R6 sitting in wheelchair rubbing eyes, no verbalizations 7:17 a.m. sitting in wheelchair in front of television rubbing eyes 7:25 a.m. siting in wheelchair in the dining, was assisted to eat by a nursing assistant (NA), no verbal interaction. 9:09 a.m. sitting in wheelchair in room, eyes closed. which continued to 9:58 a.m. 1:03 p.m. R6 was sitting in a wheelchair, in room with eyes closed, head down with chin to chest. 2:31 p.m. R6 was sitting in a wheelchair still in the room with eyes closed, head down with chin to chest. On 4/1/15, at 1:33 p.m. (nursing assistant) NA- H stated R6 did not have any observed behaviors on her shift, but had been really sick with pneumonia and "seemed worn out" since then. NA-H further stated R6 was often sleepy. On 4/1/15, at 1:46 p.m. NA-G stated she had not been observed R6 to have any mood or behaviors or combativeness. On 4/2/15, at 9:44 a.m. the pharmacy consultant stated he felt the nurse practitioner had responded appropriately at the time of the 2/24/15 recommendation. However he was unable to state whether the practitioner had addressed how the multiple acute illnesses may have affected or exacerbated R6's behaviors. In addition he stated he would expect the facility	F 329		

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F 329	Continued From page 76 staff to document any mood or behavior symptoms exhibited by R6 and confirmed the lack of behaviors noted by the practitioner. The consultant pharmacist also stated he would expect non-pharmacological interventions to be implemented and documented. On 4/2/15, at 11:12 a.m. the certified nurse practitioner (NP)-L, stated she had not decreased R6's Haldol as she had seen some behaviors during afternoon visits to the facility. She noted that she would expect facility staff to document behaviors exhibited by R6. NP-L stated she was told R6 continued to exhibit behaviors. She confirmed R6's multiple acute illnesses and stated she would likely see a general decline in R6's overall condition. Review of the facility policy, Psychotropic Medications reviewed 7/1/14, directed facility staff that medications were given to modify behavior would only be given after other alternatives had been attempted and failed. The policy further directed facility staff that once residents behavior stabilized, the psychotropic medication would be slowly tapered down per pharmacy consultant recommendations.	F 329		
F 333 SS=L	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility systemically failed to ensure	F 333	It is the practice of Lakeside Medical to ensure that resident are free of any	5/18/15

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F 333	Continued From page 77 medications were administered in a safe manner to prevent significant medication errors, resulting in actual harm for R36 who was hospitalized, had a decline in condition, and experience a more rapid progression of dementia related to having received the wrong medication. This medication error had the potential to cause immediate harm, including but not exclusive to respiratory failure and death. In addition, 3 residents (R49, R39, R58) received the wrong resident medications which had the potential to cause significant harm, including but not exclusive to cardiac (heart) complications or arrest, dehydration, hypoglycemia (low blood sugars), respiratory failure or death. The facility's systematic medication error issue resulted in an immediate jeopardy for 4 of 5 residents (R36, R49, R39, R58) who received another resident's medications. The facility also had medication omission errors, in which residents did not receive medications that were ordered for them (R57, R38, R6) including pain medications and diabetes medications. There were 23 omission errors which occurred from 7/14 to 4/15. The facility and the consultant pharmacist failed to identify and evaluate the patterns and causes of the medication errors. The facility and the consultant pharmacist failed to monitor and educate licensed staff, and did not develop and implement policies and procedures to prevent re-occurrences of medication errors. The facility's practices in medication administration and failure to ensure residents were free from significant medication errors had the potential to cause significant harm up to and including death for all of the 31 of 31 residents residing in the facility. The immediate jeopardy began on 10/13/14,	F 333	significant medication errors. Resident #6 □ Resident expired 4/30/15. Resident #36- Resident has been reviewed for significant change and care plan has been reviewed and revised by interdisciplinary team to include for staff to observe for changes and update provider. Resident #39- has been discharged. Resident #49- Resident has been reviewed for significant change and care plan has been reviewed. Resident #57 has been discharged. Resident #38- Resident has been reviewed for significant change and care plan has been reviewed. Resident #58 has been discharged. Policies and procedures regarding medication administration have been reviewed and revised to include specific directions for administration of medication, identifying residents and environmental distractions and how to handle interruptions. Medication Error Incident report has been updated to include root cause analysis and is reviewed by the Medical Director and Pharmacist Consultant. Medication Error log has been developed to assist in looking for patterns in medication errors. All medication errors are reviewed at IDT. Staff have been educated to avoid disrupting the staff member responsible for passing medications unless it is an emergency and the Medication Administration policy was updated to include directions as to what to do if interruptions occur. Licensed nurse involved in medication error for R36 was immediately re- educated. Incident was	

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F 333	Continued From page 78 when R36 received another resident's morphine sulfate (MS) Contin (extended release narcotic/opioid pain medication) and was identified on 4/2/15. The director of nursing (DON) and the assistant director of nursing (ADON) were notified of the immediate jeopardy on 4/2/15, at 5:48 p.m. The immediate jeopardy was removed on 4/8/15, at 2:35 p.m., but noncompliance remained at the scope and severity level of a G, actual harm that is not immediate jeopardy. Findings include: R36's diagnoses from the face sheet dated 4/1/15, included Alzheimer's disease, obstructive sleep apnea, chronic systolic heart failure, congestive heart failure, atrial fibrillation (an irregular heart beat), diabetes type II, tachycardia, and kidney disease Stage III (moderate kidney failure). An incident report dated 10/13/14, indicated R36 was given the wrong resident's medications. R36 received MS Contin 60 milligrams (mg) by mouth at 5:45 p.m. The report indicated the nurse practitioner (NP) and registered nurse (RN) discussed the situation including R36's medical status. The decision was made to send R36 to the hospital due to the extent of the medication error. MS Contin has the significant side effects of respiratory depression and hypotension. In addition, use of higher starting doses in patients who are not opioid tolerant (those patients not receiving high dose opioids for a week or longer) may cause fatal respiratory depression. Renal (kidney) impairment can alter the elimination of	F 333	reported to state agency on 10/14/14, fully investigated by facility and report came back from OHFC as unsubstantiated. All licensed nurses and trained medication aides were re-inserviced by pharmacy nurse consultant regarding proper medication administration techniques on 04/08/15. All nurses and trained medication aides have been audited on medication pass techniques. Systems have been placed to limit interruptions during the medication pass. All licensed staff and trained medication aides verify medication administration records for any omissions prior to end of the shift. Any noted medication error is reviewed individually daily at IDT meeting and are reviewed weekly for patterns or trends. Identification bracelets were placed on Residents (with their permission) as an additional tool for identification. Names on the outside of the resident□s rooms have been updated to include first and last names. Staff was educated to the placement of the arm bands on 04/17/15 via the communication book and again on 5/6/2015 and 5/7/2015. Any new nurse or TMA upon hire will review the medication safety book which includes medication administration policy, narcotic count policy, narcotic administration policy, medication incidents and a medication pass audit performed and a medication test prior to independently passing medications. Medication Error Log has been revised to track and trend medication errors. Residents are observed for change in condition through observations with cares,	

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F 333	Continued From page 79 MS and the metabolites resulting in drug accumulation and increased risk of toxicity. Life-threatening respiratory depression is more likely to occur in elderly patients as they may have altered pharmacokinetics or altered clearance. According to the hospital discharge summary dated 10/14/14, R36's medications prior to admission included furosemide (diuretic), Metoprolol Succinate ER (blood pressure), spironolactone (diuretic), and digoxin (heart rate). These medications had the potential to contribute to hypotension with the addition of MS Contin. The medication error investigative report dated 10/16/14, indicated the licensed practical nurse (LPN) was going to give R36 his scheduled medications on 10/13/14, at 5:00 p.m. and was interrupted by a nursing assistant (NA), stating that another resident was nauseous and wanted a medication for nausea. The LPN placed R36's medication cup in the locked medication cart while attending to the other resident. The LPN had taken that resident's morphine to her, in addition to the medication for the nausea. The other resident refused the morphine and the nurse returned to the cart and put the medication into R36's spot on the tray. The LPN saw R36 and gave him the cup of medications that was in his spot on the tray instead of the medications she had prepared for him and locked in the medication cart earlier. The LPN soon realized that she had given R36 the morphine and notified the RN on duty. The report noted R36 had been transferred by ambulance to the hospital where he stayed for under 24 hours and returned to the facility on 10/14/15. Per the nurse report from the hospital, R36 was stable during his stay. R36	F 333	shift to shift report and daily interdisciplinary team meetings. Medication pass audits and environmental audits during med pass have been performed on all licensed staff and trained medication aides. Continuing random audits will be completed a minimum of four times a week with medication pass and environmental observation audits and will be performed for one month and at minimum quarterly thereafter. Facility QAPI will review medication pass audits for trends, patterns and compliance along with Pharmacy Consultant and facility Medical Director.	

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F 333	Continued From page 80 was seen on 10/15/14, by the NP, who did not make any changes to his plan of care. Two medication pass audits for the LPN involved with the medication error, were included with the investigation report. The audits were dated 10/28/14, and 11/24/14. No other audits/education was done. No further assessment was completed to determine actual cause for the significant medication error. A nursing progress note dated 10/13/14 indicated a medication error was noted for R36, the investigation report was done, and all parties were notified. The progress note indicated R36 received Narcan (a medication to reverse the effects of a narcotic) in the ambulance on the way to the hospital. The hospital discharge summary dated 10/14/14 indicated R36's admission diagnosis was accidental overdose. The discharge summary indicated R36 received another resident's medication and was given MS Contin 60 mg by mouth. The report identified R36 did not normally take MS Contin or other scheduled narcotic medications. Emergency Medical Services (EMS) was called and thought R36 appeared sleepy so administered Narcan intravenously (IV). R36 was noted to have normal respirations in the hospital. He was monitored in the intensive care unit (ICU) and remained stable. R36's wife and nursing home staff were contacted and indicated he appeared to be at baseline. His blood pressure was noted to be low and his medications were to be held if the systolic blood pressure was less than 100. He was also noted to have a fever and tachycardia, but R36's wife requested he not be hospitalized and be sent back to the nursing home as soon as possible.	F 333		

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A nursing progress note dated 10/14/14, at 6:07 p.m. indicated R36 had returned from the hospital.

The nursing progress note dated 10/15/14, at 12:12 p.m. indicated R36 transferred with assist of 2 and mechanical stand and was wheeled in the wheelchair by staff due to increased confusion related to his recent hospital stay. The progress note also indicated that prior to his hospitalization, R36 transferred with moderate assist of 1 to 2 staff and a transfer belt with the 4-wheeled walker and ambulated with stand-by assist on and off the unit.

The NP progress note dated 10/15/14, indicated R36 had an accidental overdose of MS Contin on 10/13/14, went to the hospital to be monitored 1:1 for 24 hours, had baseline dementia and remained stable.

The nursing progress note dated 10/17/14, indicated R36 had a change in medical status that included shallow, rapid respirations and a drop in his oxygen saturation levels so oxygen was applied. The progress note further indicated his respirations remained rapid with periods of apnea (no breathing) and a fever of 99.8. He was sent to the hospital.

The hospital discharge summary dated 10/20/14, indicated R36's admission diagnoses were altered level of consciousness, renal insufficiency (decreased kidney function), dehydration and hypernatremia (elevated sodium level). The discharge summary indicated R36 had experienced these symptoms for 48 hours. R36's history included: "Patient was erroneously given

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F 333	Continued From page 82 60 mg morphine XR (extended release) in the nursing facility where he lives on 10/13 and was subsequently taken to Wyoming hospital for observation and treatment with Narcan. Upon DC (discharge) from Wyoming hospital and return to nursing facility on 10/15, nursing staff felt that patient never returned to previous mental status baseline and remained listless with decreased consumption of liquid and solid foods." Upon arrival in the emergency department, R36 had an elevated heart rate of 140 and decreased level of consciousness, which improved with IV fluids. R36's oxygen saturation levels improved with oxygen. His chest X-ray was unremarkable, his urinalysis was negative, and he had an elevated sodium of 161 (normal range of 136-145), elevated creatinine level of 2.2 (normal range of 0.60-1.30), and an elevated blood urea nitrogen of 54 (normal range 7-18), indicating dehydration. His sodium, creatinine, and blood urea nitrogen improved during the hospitalization with IV fluids. One day after admission, R36 became more alert, verbally responsive, and maintained improved mental status for the remainder of the hospitalization. The nursing progress note dated 10/20/14, at 6:56 p.m. indicated R36 had returned from the hospital at 3:30 p.m. The note identified R36 was hypotensive and returned with oxygen in use. The nursing progress note also indicated R36's transferring status had changed to a stand assist lift with 2 staff assist. The NP progress note dated 10/22/14, indicated R36 had been hospitalized from 10/13/14 through 10/14/14 due to an accidental overdose when he received another resident's morphine XR, and remained stable in the hospital. The NP noted	F 333		

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R36 had returned from the hospital but was not himself. Staff and family had noted a change in condition and R36 was sent to the hospital, where they found an elevated sodium at 161. The NP documented the elevated sodium was "due to dehydration due to not drinking from sedation from error medication" which was corrected in the hospital with IV fluids. The NP further indicated the since R36's hospitalizations, he was not back to baseline and was much less interactive.

The NP progress note dated 10/27/14, indicated R36 had been hospitalized for the overdose of MS Contin and that he did not typically take MS Contin or other scheduled narcotic medications. R36 was given Narcan and was brought to the emergency department where he had normal respirations and did not need additional Narcan. Vital signs remained stable. R36 had no ill effects.

The nursing progress note dated 10/28/14, indicated R36 did not walk and transferred with 2 staff and a stand assist lift. A nursing progress note dated 10/13/14, at 2:30 p.m., indicated R36 required stand by assistance for transfers and walked with stand by assistance of one staff and a a four-wheeled walker.

A comprehensive significant change Minimum Data Set (MDS) assessment dated 11/15/14, indicated R36 had a decline in functional status related to ambulation, eating, and locomotion, including ambulation and wheelchair mobility on and off the unit. The MDS also indicated R36 had a severe cognitive impairment and no swallowing problems. The quarterly MDS assessment dated 2/14/15, indicated R36 had a severe cognitive impairment, required extensive

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F 333	Continued From page 84 assist of 2 staff for transfers, was non-ambulatory, and required extensive assist to eat. The MDS further indicated R36 had swallowing difficulties. During random meal observations from 3/30/15 through 4/4/6/15, R36 was assisted with feeding. He was intermittently able to participate in feeding himself. He was observed to be pushed in his wheelchair by staff in the hallways and his room. He was not observed to ambulate. He was alert with episodes of sleeping in either his wheelchair or his recliner. During an interview on 4/2/15, at 9:51 a.m. the consultant pharmacist stated a single dose of morphine would have cleared in approximately 8 hours. Morphine cleared quickly. The consultant pharmacist stated he is involved in medication administration and reviews medication error reports in quality assurance (QA) meetings. During an interview on 4/2/15, at 9:34 a.m., the director of nursing (DON) verified the nurse involved in the medication error for R36, failed to identify the resident and grabbed the wrong medication for him. The DON stated R36 was sent to the hospital, had an antidote for the morphine, and had no long-standing effects. The DON stated it is not their policy to pre-set up medications and all nurses have been educated on that. The DON stated random audits are done on nurses and TMAs. She stated medication pass audits were done with the nurse involved in the error for R36. During an interview on 4/8/15, at 12:36 p.m. NP-L stated R36's morphine overdose led to the first hospitalization. NP-L stated the morphine did not	F 333		

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directly relate to his decline in condition, but the change in environment had more impact on him because he was very frail. NP-L stated it is probable that R36's dementia progressed and he declined more rapidly due to the hospitalization, because he was taken out of his environment and was also exposed to things, such as infections. NP-L stated it was doubtful he would have had such a rapid decline if R36 had only received the morphine and not gone to the hospital. NP-L stated the second hospitalization was related to lethargy and not drinking well, which was probably related to the first hospitalization with the change in environment and/or a possible pneumonia. A normal progression of R36's disease process would be an overall decline and a decrease in swallowing.

The facility failed to ensure corrections had been made to the medication administration systems to prevent further occurrences of errors involving residents receiving other resident's medications. Further incidents which had the potential to cause significant harm included:
R49 received the wrong medications. R49's diagnosis report dated 4/3/15, identified diagnoses including diabetes, dementia, explosive personality disorder and hypertension. A facility medication incident report (MIR) dated 11/8/14, revealed R49 received another resident's (R33) medications at 5:15 p.m. Although the incident report did not identify what R33's medications were, review of R33's Medication Administration Record (MAR) for 11/14 identified R49 received the following medications at that time:
Seroquel (antipsychotic medication) 12.5 mg
Lasix (diuretic) 20 mg
Propranolol (anti-hypertensive), 20 mg

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F 333	Continued From page 86 R49's 11/14, MAR indicated she also received her own medications at that time which included: Metoprolol tartrate (anti-hypertensive), 12.5 mg Trazodone (anti-depressant), 50 mg The combination of R33's medications in conjunction with R49's regular medications had a potential to cause an irregular heart beat and significant hypotension. The facility medication incident report dated 11/8/14, identified, the cause for the error was distraction and failure to identify the resident prior to administering the medication. The report indicated the nurse had been counseled regarding rules of medication pass. No other analysis of the error was completed. No education was completed or system changes were made. R39 received the wrong medications. R39 's diagnosis list dated 4/3/15, identified diagnoses included, diabetes, chronic kidney disease, long term use of insulin and edema. A facility medication incident report dated 1/31/15, revealed R39 had received another residents (R58) medications at 4:35 p.m. The incident report revealed R39 had received the following medications in error: Metformin XR (oral hypoglycemic) 1000 mg Glipizide (oral hypoglycemic) 5 mg Neurontin (neuropathic pain) 600 mg Multivitamin and fish oil. Review of R39 's MAR dated 1/15, and physician orders revealed R39 was also received his medications at that time which included: Novolog R insulin sliding scale based on blood sugars checked before all meals and before bed Lasix 80 mg R39's physician's orders dated 1/15 revealed R39 also received Toprol XL (anti-hypertensive/extended release) and NPH	F 333		

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insulin (long acting) twice a day. The combination of R39's medications in conjunction with R58's medications had the potential to cause significant hypoglycemia.
The incident report dated 1/31/15, further identified the cause of the medication error was distraction and failing to identify the resident prior to medication administration. The incident report failed to identify possible drug interactions between R39's scheduled medication and the medications received in error. There were no changes to the medication administration process, education for staff or evidence of monitoring.
R58 received the wrong medications. R58's diagnosis list dated 4/3/15, identified diagnoses included cardiac murmur, hypertension, diabetes and urinary incontinence.
A facility medication incident report dated 1/26/15, revealed R58 received another resident's (R33) medications. The report identified R58 received Lasix 80 mg by mouth in error.
A review of R58's 1/15, MAR and physician orders revealed R58 also received his own medications which included:
Metformin 1,000 mg
albuterol/ipratropium (for shortness of breath) nebulizer
Physician order's dated 1/15, identified R58 also received Lovenox (blood thinner). The addition of Lasix for R58 created the potential for hypotension.
The incident report dated 1/26/15, lacked identification of potential drug interactions, adverse reactions and monitoring for potential adverse reactions. The incident report identified the cause of the medication error to be distraction. The staff member was instructed to identify patient before giving medication. No other

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F 333	Continued From page 88 analysis, education or monitoring was done. On 4/2/15, at 11:20 a.m. the Nurse Practitioner (NP)-L stated she was notified when one of her residents was involved in a medication error. NP-L also stated she figured it was "human error" and was unaware of any patterns identified with medication errors in the facility. She further stated she felt most of the errors regarding the wrong resident had occurred in the short term care unit as "you wouldn't have time to memorize their med's" so an error on a short term care unit wouldn't be abnormal. NP-L confirmed she hadn't received any copies of the medication errors. On 4/2/15, at 11:20 a.m. physician (P)-A stated she was notified of the medication errors and would provide parameters and follow up. However, the on-call practitioner would likely be called. P-A further stated that she felt if there had been a pattern of medication errors it would be a pattern of person as "they are just med errors." On 4/2/15, at 11:47 a.m. LPN-A stated she was unaware of any in-services regarding medication administration, however may have discussed the "5 Rights" in a staff meeting. LPN-A stated she had been audited about 4-5 months ago. During an interview on 4/2/15, at 11:52 a.m. the director of nursing (DON) reported she had done verbal education with the nurses regarding medication administration and errors. She had put the education reminders in the communication book, but the book had been cleaned out and the information was no longer available. The DON stated the current medication administration process involved	F 333		

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remembering what they learned in school; to do the five checks, to go back to sign off the medication after administering it, and to make sure they do one resident at a time. The DON stated staff was not to use the medication trays except for tube feeding medication administration. The DON was informed that staff indicated during interview that trays were still being used by some nurses. Medication trays are designed to hold multiple medication cups for medication administration to multiple residents. Medication trays were used in conjunction with small medication cards to aide in medication set up. The DON was unaware the trays were still being used. If the resident refused a medication, the nurse was to reapproach the resident and hold the medications in an envelope with their name, date, and time until the resident is re-approached. If the medication is a narcotic, the nurse is to destroy the medication with another witness.

On 4/2/15, at 11:56 a.m. LPN-F, stated she could not recall any in-services on medications or medication administration. LPN-F stated the pharmacist had audited her medication pass the past year. LPN-F also stated the nurses were not involved in the process of discussing the medication errors as it was done by the interdisciplinary team (IDT.)

On 4/2/15, at 12:19 p.m. the DON stated the facility had not had any in-services or formal education on the medication administration process including errors. The DON stated they had not identified any root cause as she felt it was "human error." The DON stated she expected the nurses to remember what they learned in school.

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F 333	Continued From page 90 On 4/2/15, at 4:39 p.m. the consultant pharmacist stated he reviewed the medication error reports in the quality assurance meetings with the DON. The consultant pharmacist further stated they would look at the root cause for all the reports. During an interview and observation on 4/3/15, at 8:42 a.m. the DON demonstrated to surveyors she had removed the medication trays and put them in her office. The DON stated the nurses continued to use the small medication cards to remind them when medications are to given at off times, such as 2:00 p.m., or when there was an insulin or narcotic to give for the TMA. On 4/3/15, at 8:55 a.m. LPN- F stated she mostly worked with one trained medical assistant (TMA) and they communicated about giving the narcotic medications. LPN-F confirmed that distraction does occur during the medication pass and had been a cause for some of the errors. On 04/03/15, at 9:00 a.m. TMA-A stated she was not allowed to give out schedule I and II narcotics (such as morphine, oxycodone, Percocet, OxyContin, methadone) so a licensed nurse had to administer them. TMA-A stated she would verbally remind the LPN or RN she was working with that a medication needed to be given. During an interview on 4/3/15, at 10:53 a.m., the consultant pharmacist, DON, and the assistant administrator (AA - the AA is also a licensed RN) were informed of the findings related to medication error reviews, observations, and interviews with nursing staff. The pharmacist stated there were policies and procedures which were reviewed again that day. They were	F 333		

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F 333	Continued From page 91 reminded findings indicated the policies and procedures were not being followed. Further findings included patterns to the medication errors in when and how they occurred. Medication errors were not consistently reviewed/analyzed and the root-cause of the medication errors was not consistently determined. The DON stated using the medication trays was an old procedure and that was no longer occurring. The pharmacist stated he looked at medication errors and trends, but did not recall seeing reports that indicated a problem. Systems to address the ongoing medication errors, education and modifications in systems to correct the errors, and collaboration with the nursing staff administering medications was lacking. The consultant pharmacist stated he saw errors that were individual events and that they are addressed thoroughly on the medication incident reports. He stated that he did not discern a problem. The DON and assistant administrator stated much of the counseling with staff and discussions about incidents were done verbally and they were unable to produce documentation regarding corrective actions. The pharmacist stated he understood reviewing the patterns but didn't feel they were seeing any trends, and felt the root-cause was "human error." On 4/3/15, at 12:34 p.m. the consultant pharmacist stated he reviewed the medication incident reports quarterly and had not identified a common cause regarding the errors of medications given to the wrong resident. The consultant pharmacist also stated he had not identified a pattern regarding the medication omissions, further stating it was a "human error in performance." The consultant pharmacist also stated if a pattern had been identified a	F 333		

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F 333	Continued From page 92 discussion would have taken place with the DON in order to implement a system or process for correction. The consultant pharmacist stated he did not feel "distraction" was a pattern of cause for the medication errors. The pharmacist confirmed the medication pass audits were completed quarterly without concern. On 4/3/15, at 12:48 p.m. LPN-F stated she could not recall an error of omission regarding omitted medication. LPN-F stated she had been audited on the medication pass by the pharmacy and once by the facility though could not recall when and the facility audits were not routine. During observation on 4/4/15, at 5:33 a.m. LPN-D was observed to pass medications to a resident according to facility policy. LPN-D stated she had not been audited prior to starting her medication pass, but had received a packet of information with the updated policy and procedure for medication administration from the evening nurse. LPN-D stated she read it prior to passing medications. LPN-D stated there were not many distractions at night, but on afternoons, families asked questions, phones were ringing; someone was always trying to get attention. During the observation of medication administration on 4/4/15, at 5:33 a.m. LPN-D was observed to administer medications via G-tube (gastrostomy tube is a tube through the abdomen to directly administer food/fluids/medications) however the labels on the medications identified the medications were to be administered orally. LPN-D stated the physician's order stated to administer medications via G-tube "so that's what we do."	F 333		

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F 333	Continued From page 93 During an observation on 4/4/15, at 6:28 a.m. LPN-D provided a packet of medication administration information to LPN-A and RN-C. LPN-A read the material and stated the changes included the controlled medication keys were different, count, dot and initial the cards as at the time of removal, medication error reports were different. LPN-A stated residents would have bands on and pictures in the MAR, and there was a change in the crushing of medications. If the medication was not scored it will not be crushed. LPN-A stated she had not been audited recently; when the consultant pharmacist came in, they audited randomly and facility nursing administration had not audited her. LPN-A stated distractions included buzzers going off, staff come up and needed something, and resident needs. LPN-A stated she will ask staff to come back and remind them she is passing medications, and would address resident needs, but it did take her away from the medications. RN-C reviewed the packet of information, however spent a brief time in review before beginning multiple nursing tasks. Although packets of information were provided to nursing staff prior to medication administration, the facility had no system to ensure the packets were reviewed prior to medication pass. During a medication administration observation on 4/4/15, at 7:06 a.m. RN-C prepared medications for a resident and placed 4 medications into a medication cup. RN-C put the medication cup into a drawer of the cart and locked it. RN-C had not labeled the medication cup. RN-C then left the cart to address something with another nurse. She returned to the cart and LPN-D came to the cart to sign off three medications she had previously given. RN-C	F 333		

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F 333	Continued From page 94 removed the medication cup from the drawer and continued with the medication pass. RN-C put a dot in each appropriate box on the MAR, prior to giving the medications. When she returned to the medication cart after giving the medications, RN-C did not sign off the medications. RN-C verified she had not signed the medications off and signed the appropriate box on the MAR. RN-C stated she had been audited a couple of weeks previously by the pharmacy, and had been audited by facility staff when she began working in January. During an observation on 4/4/15, at 7:27 a.m. during the medication pass, RN-C was asked to do something for another resident. RN-C walked down the hall to the medication room, and reviewed a resident's blood sugar, prepared the insulin, went to the resident's room and administered the insulin, walked back to the nurse's station, changed her mind and walked to the medication cart to dispose of the needle. RN-C did not sign off the insulin she had just given, and stated it would be signed in a different book in the medication room. RN-C continued to pass medications. On 4/6/15, at 11:40 a.m. LPN-D could not recall the omission errors in particular however, LPN-D stated she was routinely distracted during the medication pass. LPN-D stated she had not had a medication pass audited in the past year. On 4/6/15, at 12:00 p.m. LPN-I could not recall specific events of medication errors, however did state an error likely would have happened due to distraction and overall multitasking during medication pass.	F 333		

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F 333	Continued From page 95 Interview on 4/6/15 at 1:45 p.m. with the AA and DON was completed to review progress on the IJ removal plan. The DON stated her expectation was for all staff to administer medications per policy as "they have a nursing license" so everyone knew how to administer medications. The DON further clarified she did not say she would audit each of the nursing staff "just that I was working on it." They identified they were going to provide mandatory education through their pharmacy on medication administration but the details had yet to be arranged. They confirmed they will do weekly audits of medication administration on the staff with the DON asking "so you're saying I have to watch every person pass every medication?" The AA and DON then reiterated there was a "human error piece too" and it was not reasonable to watch every staff member pass medications. The AA and DON verified that neither of them had actually observed a medication pass to assist in determining what the "distractions" were that contributed to the errors. During an interview on 4/6/15 at 8:03 p.m. LPN-E stated she had completed her medication administration, but was audited that afternoon by the DON. LPN-E identified the changes in the procedure as being the distraction process and trying to assure they are not distracted during the medication pass. She stated if there is a distraction after popping out medication from the bubble pack, they are to put the pills into an envelope, write the resident's name, date and time on the envelope. LPN-E stated they had a packet to read, which had been updated, and stated she carried it on the medication cart with her.	F 333		

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F 333	Continued From page 96 During an interview on 4/6/15, at 8:12 p.m. LPN-C stated she was done passing medications, and stated she was audited that day. LPN-C stated they were doing the dot system, which included putting a dot in the appropriate medication box on the MAR before passing the medication, and initialing it after passing the medication. She also stated the carts have a "do not disturb" sign, and if there is an emergency, they put the medications into an envelope with the name, date, and time, and put the envelope into the medication cart drawer. 'When they come back to the cart, they immediately check the pills with the dots on the MAR against the pills in the envelope and give the medications. On 4/7/15, at 8:15 a.m. LPN-G stated at times a medication would be missed (omitted) due to a miscommunication with the TMA or a card wasn ' t ' pulled. LPN-G stated she often would get distracted during a medication pass as interruptions occurred frequently. LPN-G confirmed prior to the survey date she had not been audited on the medication pass process by the pharmacy or by the facility. She further stated she was very surprised she had never had her medication pass audited after the medication errors regarding R49 and R39. She had been spoken to about the errors, however was not audited or provided with education. On 4/7/15, 2:01 p.m. the medical director stated the medication incident reports were discussed at the quarterly QA meetings. The director stated he was asked to sign a stack of MIR's he was provided the last QA meeting in January. He refused to sign them until they were formatted and reviewed to assist in allowing for analysis/tracking/trending. The medical director	F 333		

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F 333	Continued From page 97 requested the DON to compile the medication incident reports on a spreadsheet for the next QA meeting in order to clearly read the information. The director verified he had not signed the reports. The director also stated he was unaware of patterns occurring in the facility regarding the wrong resident and omission errors. He further stated he was unaware the facility staff contributing to the errors were not being audited for their medication administration nor was he aware no monitoring had been in place for corrective action. The director stated he would have expected the staff contributing to the medication errors to have had audits completed if not by the pharmacy then by the facility. He verified the QA committee had not completed any root cause analysis of the medication errors. He stated he would consider a significant medication error to be one that caused harm or could potentially cause harm to the patient. He confirmed that R39, R58 and R49's medication errors could all have been potentially significant medication errors. The medical director would expect the facility to be proactive in regards to medication administration, identifying patterns and implementing monitoring and corrective action as needed. The facility policy and procedure for Medication Administration dated 10/22/13, directed nurses and TMA's to prepare medications at the time they are administered, and identify residents before giving a medication by checking their photograph or identification band, asking the resident their name, or verifying with other personnel. The immediate jeopardy that began on 10/13/14, identified on 4/2/15, was removed on 4/8/15, at 5:48 p.m. when the facility took the following	F 333		

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F 333	Continued From page 98 steps to remove the immediacy of the situation, but the noncompliance remained at the scope and severity level of a G, an isolated occurrence which indicated actual harm that is not immediate jeopardy. After completing a root cause analysis of all facility medication errors, the facility removal plan was developed and implemented to include the following steps: The policy and procedure for medication administration was revised on 4/6/15. Changes to the policy and procedure included steps to follow should an unavoidable interruption occur, provided direction to prepare medications for only one resident at a time, and a check system to determine which medications were dispensed and administered. The nurses and the trained medication assistants (TMA) were verbally updated with the changes in the policy and procedure when they came on duty and a plan was put into place to assure all nurses and TMAs were informed of the changes. The nurses and TMA's were given a copy of the policy when they came on duty. The nursing assistants (NA) were verbally notified as they came on duty that the nurse was not to be interrupted during medication pass unless it was an emergency. Staff was to be notified of this change in writing as well. The medication error report was reviewed and revised to include the pharmacist notification and a space for the pharmacist's signature. It now required a list of medications involved, identifying	F 333		

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F 333	Continued From page 99	F 333		

if the facility procedure was followed, recommendations from the provider and/or pharmacist for additional monitoring, and notification and reporting information.

Staff was consulted regarding distractions during medication pass. The phone was to be rolled over to an automatic answering service with menu options after 5:00 p.m. to reduce the number of phone calls.

Names on the outside of the doors have been revised to include first and last name. Pictures were checked to assure they were present in all binders containing MAR's. All new admissions were to have their photograph placed in the MAR.

The daily IDT meeting template was updated to include medication errors. Each error would be discussed and analyzed daily at IDT. Root cause analysis would be completed and interventions implemented. On a weekly basis, the IDT would review any medication errors as a "unit" to determine root cause and look for trends, to assist with developing action plans.

An outside consultant would be working with the facility to review and revise clinical systems.

The pharmacy was to provide inservicing to the nurses and TMAs the week of 4/6/15.

The LPN/RN orientation checklist was updated to include a medication audit must be completed during a nurse's orientation period, before the nurse administers medications independently.

The medication pass audit form was updated to be more clear/concise and to include

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F 333	Continued From page 100 observations of environment. Signs were put on the medication carts to remind others that a medication pass was in progress and to not disturb unless it was an emergency. The facility joined the National Nursing Home Quality Care Collaborative to aid in their clinical care and QI process.	F 333		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to correctly thicken liquids for 1 of 1 residents (R68) resulting in much thicker liquids than ordered by physician. According to his admission record, R68 was admitted to the facility on 3/25/15 after a hopsitalization for acute respiratory failure. Other pertinent diagnoses listed included aspiration pneumonia and chronic airway obstruction. R68's physican orders indicated a regular diet of mechanical soft consistency and honey thick fluids. (Honey-thick liquids typically stick to the sides of a cup like honey and pour slowly versus pudding-thick liquids, which hold their own shape, are not pourable and are usually eaten with a spoon). These orders were also reflected on R68's plan of care created on 3/7/15. R68's care plan also	F 367	It is the policy of Lakeside Medical to provide therapeutic diet as prescribed by the physician. Resident #68- Resident was discharged to home on 4/15/15. Policy and procedure for liberalized geriatric diets was reviewed and revised to include thickened consistency fluids on 03/30/15. Orientation checklist for Dietary staff including education on thickened fluids and was reviewed. Nursing staff orientation checklist was revised to add thickened fluids to diet textures section. Education was provided to dietary and nursing staff on diets with modified liquids on 4/14/15 (Dietary) and 04/17/15(Nursing) staff. All staff are in the process of performing return demonstrations on proper liquid	5/18/15

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F 367	Continued From page 101 indicated that he only needs supervision while eating with cues to take small bites and chew food before taking another bite. On 4/1/15, at 10:49 a.m. R68 was seated at a dining room table with 4 other residents. At 10:52 a.m. trained medication assistant (TMA)-A added thickener to R68's orange juice and to a red juice. TMA-A then added two packets of thickener to R68's hot cocoa. At 10:59 a.m., TMA-A was observed spooning hot cocoa into R68's mouth. At 11:15 a.m. R68 was observed attempting to independently drink his hot cocoa. R68 held the cup in his right hand, tipping it down into his mouth and shaking the cup in order to attempt to get the hot cocoa from the cup into his mouth. The cocoa was too thick to pour from the glass. On 4/1/15, at 1:27 p.m., TMA-A stated she had a few days of nursing assistant training in January at the facility and thickening liquids was part of that training. She stated she has thickened liquids as part of her employment at the facility, but not often. On 4/2/15, at 9:45 a.m., Dietary Manager (DM)-A stated most of the thickened liquids used by the facility are purchased already thickened. DM-A also stated that if they are not prethickened, the dietary aides or CNA's would need to thicken the liquids. She stated dietary aides get on the job training, which is just instruction, based on package directions, and there is nothing written. In an interview on 4/2/15, at 10:10 a.m., R68 stated that he didn't like his hot cocoa that thick. He stated, "it's silly to thicken it and then I can't drink it."	F 367	thickening procedures. Kitchen orientation checklists updated to ensure proper training on diet textures and modified liquids. Communication was made with food supplier (Sysco) to assist with purchasing additional prepackaged thickened liquids. Updated Resident diet list will be given to Therapeutic Recreation department on a weekly basis. Random audits will be performed on at least 7 meals per week for proper liquid consistency for modified liquid diet orders with results reported to facility QAPI committee for compliance. Director of Nursing and Administrator are responsible for overall compliance.	

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F 367	Continued From page 102 In an interview on 4/6/15, at 5:14 p.m., the director of nursing (DON) stated that the nursing assistant training for thickening liquids is provided by other nursing assistancts who provide mentoring. The DON stated it is just one task on a training checklist, and that the mentors provide training based on the package directions. The DON also stated the facility does not have a policy for thickening liquids.	F 367		
F 425 SS=L	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility systemically failed to ensure	F 425	It is the practice of Lakeside Medical to ensure that resident are free of any	5/18/15

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F 425	Continued From page 103 medications were administered in a safe manner to prevent medication errors, resulting in actual harm for R36 who was hospitalized, had a decline in condition, and experience a more rapid progression of dementia related to having received the wrong medication. This medication error had the potential to cause immediate harm, including but not exclusive to respiratory failure and death. In addition, 3 residents (R49, R39, R58) received the wrong resident medications which had the potential to cause significant harm, including but not exclusive to cardiac (heart) complications or arrest, dehydration, hypoglycemia (low blood sugars), respiratory failure or death. The facility's systematic medication error issue resulted in an immediate jeopardy for 4 of 5 residents (R36, R49, R39, R58) who received another resident's medications. The facility also had medication omission errors, in which residents did not receive medications that were ordered for them (R57, R38, R6) including pain medications and diabetes medications. There were 23 omission errors which occurred from 7/14 to 4/15. The facility and the consultant pharmacist failed to identify and evaluate the patterns and causes of the medication errors. The facility and the consultant pharmacist failed to monitor and educate licensed staff, and did not develop and implement policies and procedures to prevent re-occurrences of medication errors. The facility's practices in medication administration and failure to ensure residents were free from medication errors had the potential to cause significant harm up to and including death for all of the 31 of 31 residents residing in the facility. The immediate jeopardy began on 10/13/14, when R36 received another resident's morphine	F 425	significant medication errors. Resident #6 □ Resident expired 4/30/15. Resident #36- Resident has been reviewed for significant change and care plan has been reviewed and revised by interdisciplinary team to include for staff to observe for changes and update provider. Resident #39- has been discharged. Resident #49- Resident has been reviewed for significant change and care plan has been reviewed. Resident #57 has been discharged. Resident #38- Resident has been reviewed for significant change and care plan has been reviewed. Resident #58 has been discharged. Policies and procedures regarding medication administration have been reviewed and revised to include specific directions for administration of medication, identifying residents and environmental distractions and how to handle interruptions. Medication Error Incident report has been updated to include root cause analysis and is reviewed by the Medical Director and Pharmacist Consultant. Medication Error log has been developed to assist in looking for patterns in medication errors. All medication errors are reviewed at IDT. Staff have been educated to avoid disrupting the staff member responsible for passing medications unless it is an emergency and the Medication Administration policy was updated to include directions as to what to do if interruptions occur. Licensed nurse involved in medication error for R36 was immediately re- educated. Incident was	

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F 425	Continued From page 104 sulfate (MS) Contin (extended release narcotic/opioid pain medication) and was identified on 4/2/15. The director of nursing (DON) and the assistant director of nursing (ADON) were notified of the immediate jeopardy on 4/2/15, at 5:48 p.m. The immediate jeopardy was removed on 4/8/15, at 2:35 p.m., but noncompliance remained at the scope and severity level of a G, actual harm that is not immediate jeopardy. Findings include: R36's face sheet document dated 4/1/15, identified active diagnoses including: Alzheimer's disease, obstructive sleep apnea, chronic systolic heart failure, congestive heart failure, atrial fibrillation (an irregular heart beat), diabetes type II, tachycardia, and kidney disease Stage III (moderate kidney failure). An incident report dated 10/13/14, indicated R36 was given the wrong resident's medications. The incident report indicated R36 had received MS Contin 60 milligrams (mg) by mouth at 5:45 p.m. on 10/13/14. The report indicated the nurse practitioner (NP) and a registered nurse (RN) had discussed the situation including R36's medical status. The decision was made to send R36 to the hospital due to the extent of the medication error. According to the consumer version of the on line Physician's Desk Reference, MS Contin has the significant side effects of respiratory depression and hypotension. In addition, use of higher starting doses in patients who are not opioid tolerant (those patients not receiving high dose opioid's for a week or longer) may cause fatal	F 425	reported to state agency on 10/14/14, fully investigated by facility and report came back from OHFC as unsubstantiated. All licensed nurses and trained medication aides were re-inserviced by pharmacy nurse consultant regarding proper medication administration techniques on 04/08/15. All nurses and trained medication aides have been audited on medication pass techniques. Systems have been placed to limit interruptions during the medication pass. All licensed staff and trained medication aides verify medication administration records for any omissions prior to end of the shift. Any noted medication error is reviewed individually daily at IDT meeting and are reviewed weekly for patterns or trends. Identification bracelets were placed on Residents (with their permission) as an additional tool for identification. Names on the outside of the resident□s rooms have been updated to include first and last names. Staff was educated to the placement of the arm bands on 04/17/15 via the communication book and again on 5/6/2015 and 5/7/2015. Any new nurse or TMA upon hire will review the medication safety book which includes medication administration policy, narcotic count policy, narcotic administration policy, medication incidents and a medication pass audit performed and a medication test prior to independently passing medications. Medication Error Log has been revised to track and trend medication errors. Residents are observed for change in condition through observations with cares,	

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F 425	Continued From page 105 respiratory depression. Renal (kidney) impairment can alter the elimination of MS and the metabolites resulting in drug accumulation and increased risk of toxicity. Life-threatening respiratory depression is more likely to occur in elderly patients as they may have altered pharmacokinetics or altered clearance. According to R36's hospital discharge summary dated 10/14/14, medications prior to admission included furosemide (a diuretic), Metoprolol Succinate ER (to treat blood pressure), spironolactone (a diuretic), and digoxin (to modify heart rate). These medications had the potential to contribute to hypotension with the addition of MS Contin. The medication error investigative report dated 10/16/14, indicated a licensed practical nurse (LPN) was going to give R36 his scheduled medications on 10/13/14, at 5:00 p.m. and had been interrupted by a nursing assistant (NA), stating that another resident was nauseous and wanted a medication for nausea. According to the report, the LPN had placed R36's medication cup in the locked medication cart while attending to the other resident. The LPN had taken that resident's morphine to her, in addition to the medication for the nausea. The other resident had refused their morphine and when the nurse had returned the morphine to the cart, she'd put the medication into R36's spot on the tray. The LPN saw R36 and gave him the cup of medications that was in his spot on the tray instead of the medications she'd previously prepared and locked in the medication cart. When the LPN realized that she'd given R36 the morphine, she had notified the RN on duty. The investigative report indicated R36 had	F 425	shift to shift report and daily interdisciplinary team meetings. Medication pass audits and environmental audits during med pass have been performed on all licensed staff and trained medication aides. Continuing random audits will be completed a minimum of four times a week with medication pass and environmental observation audits and will be performed for one month and at minimum quarterly thereafter. Facility QAPI will review medication pass audits for trends, patterns and compliance along with Pharmacy Consultant and facility Medical Director.	

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F 425	Continued From page 106 subsequently been transferred by ambulance to the hospital where he stayed for less than 24 hours, and then had returned to the facility on 10/14/15. Per a hospital nurse's report from the hospital, R36 had been stable during his hospital stay. R36 was seen on 10/15/14, by the NP, who did not make any changes to his plan of care. Two medication pass audits for the LPN involved with the medication error were included with the investigation report. The audits were dated 10/28/14, and 11/24/14. No other audits/education was documented as having been done. In addition, there had been no further assessment completed to determine actual cause for the significant medication error. A nursing progress note dated 10/13/14, indicated a medication error had occurred for R36, the investigation report was done, and all parties were notified. The progress note also indicated R36 had received Narcan (a medication to reverse the effects of a narcotic) in the ambulance on the way to the hospital. The hospital discharge summary for R36 dated 10/14/14, identified R36's hospital admission diagnosis was accidental overdose. The discharge summary indicated R36 had received another resident's medication, MS Contin 60 mg by mouth. The report identified R36 did not normally take MS Contin or other scheduled narcotic medications and that Emergency Medical Services (EMS), had been called. The report further indicated the EMS staff had thought R36 appeared sleepy so Narcan intravenous (IV) had been administered. R36 was noted to have normal respirations in the hospital. He was monitored in the intensive care unit (ICU) and had remained stable. R36's wife and nursing home	F 425		

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staff had been contacted and informed he appeared to be at baseline. In addition, during hospitalization R36's blood pressure had been noted to be low, and his medications were to be held if the systolic blood pressure was less than 100. In addition, he had also been noted to have a fever and tachycardia, however his wife had requested he not remain hospitalized and that he be sent back to the nursing home as soon as possible.

A nursing progress note dated 10/14/14, at 6:07 p.m. indicated R36 had returned from the hospital.

The nursing progress note dated 10/15/14, at 12:12 p.m. indicated R36 transferred with assist of 2 and mechanical stand and was wheeled in the wheelchair by staff due to increased confusion related to his recent hospital stay. The progress note also indicated that prior to his hospitalization, R36 transferred with moderate assist of 1 to 2 staff and a transfer belt with a 4-wheeled walker, and ambulated with stand-by assist on and off the unit.

An NP progress note dated 10/15/14, indicated R36 had received an accidental overdose of MS Contin on 10/13/14, had gone to the hospital to be monitored 1:1 for 24 hours, had baseline dementia and remained stable.

A nursing progress note dated 10/17/14, indicated R36 had a change in medical status that included shallow, rapid respirations and a drop in his oxygen saturation levels so oxygen had been applied. The progress note further indicated R36's respirations remained rapid with periods of apnea (no breathing) and a fever of 99.8. On

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F 425	Continued From page 108 10/17/14, R36 was sent back to the hospital. The hospital discharge summary dated 10/20/14, indicated R36's admission diagnoses included altered level of consciousness, renal insufficiency (decreased kidney function), dehydration and hypernatremia (elevated sodium level). The discharge summary indicated R36 had experienced these symptoms for 48 hours. R36's history included: "Patient was erroneously given 60 mg morphine XR (extended release) in the nursing facility where he lives on 10/13 and was subsequently taken to Wyoming hospital for observation and treatment with Narcan. Upon DC (discharge) from Wyoming hospital and return to nursing facility on 10/15, nursing staff felt that patient never returned to previous mental status baseline and remained listless with decreased consumption of liquid and solid foods." According to hospital records, upon arrival in the emergency department, R36 had an elevated heart rate of 140 and decreased level of consciousness, which improved with IV fluids. R36's oxygen saturation levels had improved with oxygen. His chest X-ray was unremarkable, his urinalysis was negative, and he had an elevated sodium of 161 (normal range of 136-145), elevated creatinine level of 2.2 (normal range of 0.60-1.30), and an elevated blood urea nitrogen of 54 (normal range 7-18), indicating dehydration. His sodium, creatinine, and blood urea nitrogen improved during the hospitalization with IV fluids. The hospital notes also identified that one day after admission, R36 had become more alert, verbally responsive, and had maintained improved mental status for the remainder of the hospitalization. A nursing progress note dated 10/20/14, at 6:56 p.m. indicated R36 had returned from the hospital	F 425		

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at 3:30 p.m. The note identified R36 was hypotensive and returned with oxygen in use. The nursing progress note also indicated R36's transferring status had changed to a stand assist lift with 2 staff assist.

An NP progress note dated 10/22/14, indicated R36 had been hospitalized from 10/13/14 through 10/14/14 due to an accidental overdose when he received another resident's morphine XR, and had remained stable in the hospital. The NP note also indicated R36 had returned from the hospital but was not himself, staff and family had noted a change in condition and R36 had been sent back to the hospital, where they'd found an elevated sodium at 161. The NP documented the elevated sodium was "due to dehydration due to not drinking from sedation from error medication" which was corrected in the hospital with IV fluids. The NP note further indicated that since R36's hospitalizations, he was not back to baseline and was much less interactive.

Although the note was contradictory to hospital progress notes, a NP progress note dated 10/27/14, indicated R36 had been hospitalized for the overdose of MS Contin and that he did not typically take MS Contin or other scheduled narcotic medications. R36 was given Narcan and was brought to the emergency department where he had normal respirations and did not need additional Narcan. Vital signs remained stable. R36 had no ill effects.

A comprehensive significant change Minimum Data Set (MDS) assessment dated 11/15/14, indicated R36 had a decline in functional status in ambulation, eating and locomotion, which included ambulation and wheelchair mobility on

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and off the unit. The MDS also indicated R36 had severe cognitive impairment. A quarterly MDS assessment dated 2/14/15, indicated R36 had a severe cognitive impairment, required extensive assist of 2 staff for transfers, was non-ambulatory, and required extensive assist to eat.

During observations at random meals from 3/30/15 through 4/6/15, R36 was observed to be pushed in his wheelchair by staff in the hallways and in his room. He was not observed to ambulate. He was alert with episodes of sleeping in either his wheelchair or his recliner.

During an interview on 4/2/15, at 9:51 a.m. the consultant pharmacist stated a single dose of morphine would have cleared in approximately 8 hours because morphine cleared quickly. The consultant pharmacist stated he is involved in medication administration and medication error report reviews at quality assurance (QA) meetings.

During an interview on 4/2/15, at 9:34 a.m., the director of nursing (DON) verified the nurse involved in the medication error for R36, failed to identify the resident and grabbed the wrong medication for him. The DON stated R36 was sent to the hospital, had an antidote for the morphine, and had no long-standing effects. The DON stated it is not their policy to pre-set up medications and all nurses have been educated on that. The DON stated random audits are done on nurses and trained medication aides. She stated medication pass audits had been done with the nurse involved in the error for R36.

During an interview on 4/8/15, at 12:36 p.m. NP-L

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F 425	Continued From page 111 stated R36's morphine overdose led to the first hospitalization. NP-L stated the morphine did not directly relate to his decline in condition, but the change in environment had more impact on him because he was very frail. NP-L stated it is probable that R36's dementia progressed and he declined more rapidly due to the hospitalization, because he was taken out of his environment and was also exposed to things, such as infections. NP-L stated it was doubtful he would have had such a rapid decline if R36 had only received the morphine and not gone to the hospital. NP-L stated the second hospitalization was related to lethargy and not drinking well, which was probably related to the first hospitalization with the change in environment and/or a possible pneumonia. A normal progression of R36's disease process would be an overall decline and a decrease in swallowing. The facility failed to ensure corrections had been made to the medication administration systems to prevent further occurrences of errors involving residents receiving other resident's medications. Further incidents which had the potential to cause significant harm included: R49 received the wrong medications. R49's diagnosis report dated 4/3/15, identified diagnoses including: diabetes, dementia, explosive personality disorder and hypertension. A facility medication incident report dated 11/8/14, revealed R49 had received another resident's (R33) medications at 5:15 p.m. Although the incident report did not identify what R33's medications were, review of R33's Medication Administration Record (MAR) for 11/14 identified R49 received the following medications at that time: Seroquel (antipsychotic medication) 12.5 mg	F 425		

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F 425	Continued From page 112 Lasix (diuretic) 20 mg Propranolol (anti-hypertensive) 20 mg A review of R49's 11/14 MAR indicated she had also received her own medications on 11/8/14 which included: Metoprolol tartrate (anti-hypertensive) 12.5 mg Trazodone (anti-depressant) 50 mg The facility medication incident report dated 11/8/14, identified the cause for the error was distraction and failure to identify the resident prior to administering the medication. The report indicated the nurse had been counseled regarding rules of medication pass following the error. No other analysis of the error was completed. No education was completed or changes made. R39 received the wrong medications. R39's diagnosis list dated 4/3/15, identified diagnoses including: diabetes, chronic kidney disease, long term use of insulin and edema. A facility medication incident report dated 1/31/15, revealed R39 had received another resident's (R58) medications at 4:35 p.m. The incident report revealed R39 had received the following medications in error: Metformin XR (oral hypoglycemic) 1000 mg Glipizide (oral hypoglycemic) 5 mg Neurontin (neuropathic pain) 600 mg Multivitamin and fish oil. Review of R39 's MAR dated 1/15, and a review of physician orders, revealed R39 had also received his own medications at that time which included: Novolog R insulin, sliding scale based on blood sugars, checked before all meals and before bed Lasix 80 mg R39's physician's orders dated 1/15 revealed R39 also received Toprol XL (anti-hypertensive/extended release) and NPH	F 425		

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F 425	Continued From page 113 insulin (long acting) twice a day. The incident report dated 1/31/15, identified the cause of the medication error as distraction and failure to identify the resident prior to medication administration. The incident report failed to identify possible drug interactions between R39's scheduled medication and the medications received in error. There were no changes to the medication administration process, education for staff, or evidence of monitoring following the error. R58 received the wrong medications. R58's diagnosis list dated 4/3/15, identified diagnoses including: cardiac murmur, hypertension, diabetes and urinary incontinence. A facility medication incident report dated 1/26/15, revealed R58 had received another resident's (R33) medications. The report identified R58 had received Lasix 80 mg by mouth in error. A review of R58's 1/15, MAR, and review of the corresponding physician orders, revealed R58 had also received his own medications which included: Metformin 1,000 mg albuterol/ipratropium (for shortness of breath) nebulizer The physician order's dated 1/15, identified R58 also had orders to receive Lovenox (a blood thinner). The incident report dated 1/26/15, lacked identification of potential drug interactions, adverse reactions and monitoring for potential adverse reactions. The incident report identified the cause of the medication error to be distraction. According to the report, the staff member had been instructed to identify the patient prior to giving medication. No other analysis, education or monitoring was documented as having been done.	F 425		

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F 425	Continued From page 114 Review of the facility's medication incident reports also revealed multiple omitted medications. Examples included: R57's diagnosis report identified R57's diagnoses included, diabetes with long term insulin use. The facility medication incident report dated 12/12/14, indicated R57's 4:30 p.m. insulin dose of Humalog mix (fast acting insulin usually given right before meals) 10 units was omitted. The incident report lacked a causal analysis, however did identify poor communication between nursing staff regarding who was to administer the medication. The report also lacked identification of potential consequences from omission, monitoring and corrective action. R38's diagnosis report identified R38's diagnoses included chronic pain, anxiety, schizophrenia and depression. The facility medication incident report (MIR) dated 2/6/15, revealed on 2/4/15, R38's 8:00 a.m. dose of Klonopin (anti-anxiety) 1 mg was missed. The report identified the trained medication assistant (TMA) thought the medication needed to be given by the nurse. According to MIR's R38 also had the following omissions: 1/6/15 - Neurontin (pain medication) 200 mg 10/4/14, 10/5/14, 10/6/14 - OxyContin (narcotic pain medication) 10 mg 9/23/14, 9/24/14,/9/27/14,/9/28/14, 9/29/14, 9/30/14 - Simvastatin (cholesterol lowering) 40 mg and Trazadone (antidepressant) 200 mg Although "distractions" was generally identified as contributing to the errors, there was no analysis of the causal factor for the ongoing medication errors. The reports also lacked identification of the potential consequences from the omissions, monitoring and corrective actions. R6's diagnosis report identified R6's diagnoses included generalized pain, pain of limbs,	F 425		

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F 425	Continued From page 115 backache and Parkinson's disease. Review of R6's MAR dated 1/15, revealed a physician's order for tramadol (non-opioid analgesic) 50 mg by mouth at bedtime for pain. Review of a facility MIR dated 1/12/15, revealed R6's bedtime tramadol was omitted. The report identified distraction as the cause of the medication error. The report lacked potential consequences to the omission, physician's response, and any monitoring implemented or corrective actions taken. Review of the facilities medication incident reports from 7/14 to 3/15, revealed an additional 19 omission errors, 9 incorrect doses, 5 transcription errors and 3 additional errors in which residents received another resident's medications. Review identified medication error were made by multiple staff members including RN, LPN, and TMA staff. The facility medication incident reports routinely lacked a medical directors signature, notification to the pharmacy, physician response, potential side effects, effects on the resident, and a causal analysis for the error. In addition there was no evidence the medication errors were being reviewed in a systematic format to assist with tracking and trending any potential patterns with the errors to aide in making appropriate system changes, educating nursing staff as a group, and monitoring the system for the changes made. Review of the medication audits completed by the facility and consulting pharmacist from 7/14 to 3/15 revealed staff was inconsistently audited with some staff audited more than once and some staff not audited at all. Upon review of the nursing staff responsible for medication errors against the audits, staff responsible for medication errors were not consistently audited. On 4/2/15, at 11:20 a.m. the Nurse Practitioner	F 425		

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(NP)-L stated she was notified when one of her residents was involved in a medication error. NP-L also stated she figured it was "human error" and was unaware of any patterns identified with medication errors in the facility. She further stated she felt most of the errors regarding the wrong resident had occurred in the short term care unit as "you wouldn't have time to memorize their med's" so an error on a short term care unit wouldn't be abnormal. NP-L confirmed she hadn't received any copies of the medication errors.

On 4/2/15, at 11:20 a.m. physician (P)-A stated she was notified of the medication errors and would provide parameters and follow up. However, the on-call practitioner would likely be called. P-A further stated that she felt if there had been a pattern of medication errors it would be a pattern of person as "they are just med errors."

On 4/2/15, at 11:47 a.m. LPN-A stated she was unaware of any in-services regarding medication administration, however may have discussed the "5 Rights" in a staff meeting. LPN-A stated she had been audited about 4-5 months ago.

During an interview on 4/2/15, at 11:52 a.m. the director of nursing (DON) reported she had done verbal education with the nurses regarding medication administration and errors. She had put the education reminders in the communication book, but the book had been cleaned out and the information was no longer available. The DON stated the current medication administration process involved remembering what they learned in school; to do the five checks, to go back to sign off the medication after administering it, and to make

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sure they do one resident at a time. The DON stated staff was not to use the medication trays except for tube feeding medication administration. The DON was informed that staff indicated during interview that trays were still being used by some nurses. Medication trays are designed to hold multiple medication cups for medication administration to multiple residents. Medication trays were used in conjunction with small medication cards to aide in medication set up. The DON was unaware the trays were still being used. If the resident refused a medication, the nurse was to reapproach the resident and hold the medications in an envelope with their name, date, and time until the resident is re-approached. If the medication is a narcotic, the nurse is to destroy the medication with another witness.

On 4/2/15, at 11:56 a.m. LPN-F, stated she could not recall any in-services on medications or medication administration. LPN-F stated the pharmacist had audited her medication pass the past year. LPN-F also stated the nurses were not involved in the process of discussing the medication errors as it was done by the interdisciplinary team (IDT.)

On 4/2/15, at 12:19 p.m. the DON stated the facility had not had any in-services or formal education on the medication administration process including errors. The DON stated they had not identified any root cause as she felt it was "human error." The DON stated she expected the nurses to remember what they learned in school.

On 4/2/15, at 4:39 p.m. the consultant pharmacist stated he reviewed the medication error reports in

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F 425	Continued From page 118 the quality assurance meetings with the DON. The consultant pharmacist further stated they would look at the root cause for all the reports. During an interview and observation on 4/3/15, at 8:42 a.m. the DON demonstrated to surveyors she had removed the medication trays and put them in her office. The DON stated the nurses continued to use the small medication cards to remind them when medications are to given at off times, such as 2:00 p.m., or when there was an insulin or narcotic to give for the TMA. On 4/3/15, at 8:55 a.m. LPN- F stated she mostly worked with one trained medical assistant (TMA) and they communicated about giving the narcotic medications. LPN-F confirmed that distraction does occur during the medication pass and had been a cause for some of the errors. On 04/03/15, at 9:00 a.m. TMA-A stated she was not allowed to give out schedule I and II narcotics (such as morphine, oxycodone, Percocet, OxyContin, methadone) so a licensed nurse had to administer them. TMA-A stated she would verbally remind the LPN or RN she was working with that a medication needed to be given. During an interview on 4/3/15, at 10:53 a.m., the consultant pharmacist, DON, and the assistant administrator (AA - the AA is also a licensed RN) were informed of the findings related to medication error reviews, observations, and interviews with nursing staff. The pharmacist stated there were policies and procedures which were reviewed again that day. They were reminded findings indicated the policies and procedures were not being followed. Further findings included patterns to the medication	F 425		

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errors in when and how they occurred. Medication errors were not consistently reviewed/analyzed and the root-cause of the medication errors was not consistently determined. The DON stated using the medication trays was an old procedure and that was no longer occurring. The pharmacist stated he looked at medication errors and trends, but did not recall seeing reports that indicated a problem. Systems to address the ongoing medication errors, education and modifications in systems to correct the errors, and collaboration with the nursing staff administering medications was lacking. The consultant pharmacist stated he saw errors that were individual events and that they are addressed thoroughly on the medication incident reports. He stated that he did not discern a problem. The DON and assistant administrator stated much of the counseling with staff and discussions about incidents were done verbally and they were unable to produce documentation regarding corrective actions. The pharmacist stated he understood reviewing the patterns but didn't feel they were seeing any trends, and felt the root-cause was "human error."

On 4/3/15, at 12:34 p.m. the consultant pharmacist stated he reviewed the medication incident reports quarterly and had not identified a common cause regarding the errors of medications given to the wrong resident. The consultant pharmacist also stated he had not identified a pattern regarding the medication omissions, further stating it was a "human error in performance." The consultant pharmacist also stated if a pattern had been identified a discussion would have taken place with the DON in order to implement a system or process for correction. The consultant pharmacist stated he

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F 425	Continued From page 120 did not feel "distraction" was a pattern of cause for the medication errors. The pharmacist confirmed the medication pass audits were completed quarterly without concern. On 4/3/15, at 12:48 p.m. LPN-F stated she could not recall an error of omission regarding omitted medication. LPN-F stated she had been audited on the medication pass by the pharmacy and once by the facility though could not recall when and the facility audits were not routine. During observation on 4/4/15, at 5:33 a.m. LPN-D was observed to pass medications to a resident according to facility policy. LPN-D stated she had not been audited prior to starting her medication pass, but had received a packet of information with the updated policy and procedure for medication administration from the evening nurse. LPN-D stated she read it prior to passing medications. LPN-D stated there were not many distractions at night, but on afternoons, families asked questions, phones were ringing; someone was always trying to get attention. During the observation of medication administration on 4/4/15, at 5:33 a.m. LPN-D was observed to administer medications via G-tube (gastrostomy tube is a tube through the abdomen to directly administer food/fluids/medications) however the labels on the medications identified the medications were to be administered orally. LPN-D stated the physician's order stated to administer medications via G-tube "so that's what we do." During an observation on 4/4/15, at 6:28 a.m. LPN-D provided a packet of medication administration information to LPN-A and RN-C.	F 425		

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F 425	Continued From page 121 LPN-A read the material and stated the changes included the controlled medication keys were different, count, dot and initial the cards as at the time of removal, medication error reports were different. LPN-A stated residents would have bands on and pictures in the MAR, and there was a change in the crushing of medications. If the medication was not scored it will not be crushed. LPN-A stated she had not been audited recently; when the consultant pharmacist came in, they audited randomly and facility nursing administration had not audited her. LPN-A stated distractions included buzzers going off, staff come up and needed something, and resident needs. LPN-A stated she will ask staff to come back and remind them she is passing medications, and would address resident needs, but it did take her away from the medications. RN-C reviewed the packet of information, however spent a brief time in review before beginning multiple nursing tasks. Although packets of information were provided to nursing staff prior to medication administration, the facility had no system to ensure the packets were reviewed prior to medication pass. During a medication administration observation on 4/4/15, at 7:06 a.m. RN-C prepared medications for a resident and placed 4 medications into a medication cup. RN-C put the medication cup into a drawer of the cart and locked it. RN-C had not labeled the medication cup. RN-C then left the cart to address something with another nurse. She returned to the cart and LPN-D came to the cart to sign off three medications she had previously given. RN-C removed the medication cup from the drawer and continued with the medication pass. RN-C put a dot in each appropriate box on the MAR, prior to	F 425		

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F 425	Continued From page 122 giving the medications. When she returned to the medication cart after giving the medications, RN-C did not sign off the medications. RN-C verified she had not signed the medications off and signed the appropriate box on the MAR. RN-C stated she had been audited a couple of weeks previously by the pharmacy, and had been audited by facility staff when she began working in January. During an observation on 4/4/15, at 7:27 a.m. during the medication pass, RN-C was asked to do something for another resident. RN-C walked down the hall to the medication room, and reviewed a resident's blood sugar, prepared the insulin, went to the resident's room and administered the insulin, walked back to the nurse's station, changed her mind and walked to the medication cart to dispose of the needle. RN-C did not sign off the insulin she had just given, and stated it would be signed in a different book in the medication room. RN-C continued to pass medications. On 4/6/15, at 11:40 a.m. LPN-D could not recall the omission errors in particular however, LPN-D stated she was routinely distracted during the medication pass. LPN-D stated she had not had a medication pass audited in the past year. On 4/6/15, at 12:00 p.m. LPN-I could not recall specific events of medication errors, however did state an error likely would have happened due to distraction and overall multitasking during medication pass. Interview on 4/6/15 at 1:45 p.m. with the AA and DON was completed to review progress on the IJ removal plan. The DON stated her expectation	F 425		

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was for all staff to administer medications per policy as "they have a nursing license" so everyone knew how to administer medications. The DON further clarified she did not say she would audit each of the nursing staff "just that I was working on it." They identified they were going to provide mandatory education through their pharmacy on medication administration but the details had yet to be arranged. They confirmed they will do weekly audits of medication administration on the staff with the DON asking "so you're saying I have to watch every person pass every medication?" The AA and DON then reiterated there was a "human error piece too" and it was not reasonable to watch every staff member pass medications. The AA and DON verified that neither of them had actually observed a medication pass to assist in determining what the "distractions" were that contributed to the errors.

During an interview on 4/6/15 at 8:03 p.m. LPN-E stated she had completed her medication administration, but was audited that afternoon by the DON. LPN-E identified the changes in the procedure as being the distraction process and trying to assure they are not distracted during the medication pass. She stated if there is a distraction after popping out medication from the bubble pack, they are to put the pills into an envelope, write the resident's name, date and time on the envelope. LPN-E stated they had a packet to read, which had been updated, and stated she carried it on the medication cart with her.

During an interview on 4/6/15, at 8:12 p.m. LPN-C stated she was done passing medications, and stated she was audited that day. LPN-C

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F 425	Continued From page 124 stated they were doing the dot system, which included putting a dot in the appropriate medication box on the MAR before passing the medication, and initialing it after passing the medication. She also stated the carts have a "do not disturb" sign, and if there is an emergency, they put the medications into an envelope with the name, date, and time, and put the envelope into the medication cart drawer. 'When they come back to the cart, they immediately check the pills with the dots on the MAR against the pills in the envelope and give the medications. On 4/7/15, at 8:15 a.m. LPN-G stated at times a medication would be missed (omitted) due to a miscommunication with the TMA or a card wasn ' t ' pulled. LPN-G stated she often would get distracted during a medication pass as interruptions occurred frequently. LPN-G confirmed prior to the survey date she had not been audited on the medication pass process by the pharmacy or by the facility. She further stated she was very surprised she had never had her medication pass audited after the medication errors regarding R49 and R39. She had been spoken to about the errors, however was not audited or provided with education. On 4/7/15, 2:01 p.m. the medical director stated the medication incident reports were discussed at the quarterly QA meetings. The director stated he was asked to sign a stack of MIR's he was provided the last QA meeting in January. He refused to sign them until they were formatted and reviewed to assist in allowing for analysis/tracking/trending. The medical director requested the DON to compile the medication incident reports on a spreadsheet for the next QA meeting in order to clearly read the information.	F 425		

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F 425	Continued From page 125 The director verified he had not signed the reports. The director also stated he was unaware of patterns occurring in the facility regarding the wrong resident and omission errors. He further stated he was unaware the facility staff contributing to the errors were not being audited for their medication administration nor was he aware no monitoring had been in place for corrective action. The director stated he would have expected the staff contributing to the medication errors to have had audits completed if not by the pharmacy then by the facility. He verified the QA committee had not completed any root cause analysis of the medication errors. He stated he would consider a significant medication error to be one that caused harm or could potentially cause harm to the patient. He confirmed that R39, R58 and R49's medication errors could all have been potentially significant medication errors. The medical director would expect the facility to be proactive in regards to medication administration, identifying patterns and implementing monitoring and corrective action as needed. The facility policy and procedure for Medication Administration dated 10/22/13, directed nurses and TMA's to prepare medications at the time they are administered, and identify residents before giving a medication by checking their photograph or identification band, asking the resident their name, or verifying with other personnel. The immediate jeopardy that began on 10/13/14, and identified on 4/2/15, was removed on 4/8/15, at 5:48 p.m. when the facility took the following steps to remove the immediacy of the situation, but the noncompliance remained at the scope	F 425		

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F 425	Continued From page 126 and severity level of a G, an isolated occurrence which indicated actual harm that is not immediate jeopardy. After completing a root cause analysis of all facility medication errors, the facility removal plan was developed and implemented to include the following steps: The policy and procedure for medication administration was revised on 4/6/15. Changes to the policy and procedure included steps to follow should an unavoidable interruption occur, provided direction to prepare medications for only one resident at a time, and a check system to determine which medications were dispensed and administered. The nurses and the trained medication assistants (TMA) were verbally updated with the changes in the policy and procedure when they came on duty and a plan was put into place to assure all nurses and TMAs were informed of the changes. The nurses and TMA's were given a copy of the policy when they came on duty. The nursing assistants (NA) were verbally notified as they came on duty that the nurse was not to be interrupted during medication pass unless it was an emergency. Staff was to be notified of this change in writing as well. The medication error report was reviewed and revised to include the pharmacist notification and a space for the pharmacist's signature. It now required a list of medications involved, identifying if the facility procedure was followed, recommendations from the provider and/or	F 425		

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F 425	Continued From page 127 pharmacist for additional monitoring, and notification and reporting information. Staff was consulted regarding distractions during medication pass. The phone was to be rolled over to an automatic answering service with menu options after 5:00 p.m. to reduce the number of phone calls. Names on the outside of the doors have been revised to include first and last name. Pictures were checked to assure they were present in all binders containing MAR's. All new admissions were to have their photograph placed in the MAR. The daily IDT meeting template was updated to include medication errors. Each error would be discussed and analyzed daily at IDT. Root cause analysis would be completed and interventions implemented. On a weekly basis, the IDT would review any medication errors as a "unit" to determine root cause and look for trends, to assist with developing action plans. An outside consultant would be working with the facility to review and revise clinical systems. The pharmacy was to provide inservicing to the nurses and TMAs the week of 4/6/15. The LPN/RN orientation checklist was updated to include a medication audit must be completed during a nurse's orientation period, before the nurse administers medications independently. The medication pass audit form was updated to be more clear/concise and to include observations of environment.	F 425		

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F 425	Continued From page 128 Signs were put on the medication carts to remind others that a medication pass was in progress and to not disturb unless it was an emergency. The facility joined the National Nursing Home Quality Care Collaborative to aid in their clinical care and QI process.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		5/18/15

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F 441	Continued From page 129 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper disposal of a needle following an injection for 1 of 1 resident (R49) observed during insulin administration. Findings include: During an observation on 4/4/15 at 7:27 a.m., registered nurse (RN)-C was observed to administer insulin (medication injected to control blood sugars) to R49. Following the insulin injection, RN-C held up the exposed needle and began to exit the room with the exposed, contaminated needle and syringe in her hand. When asked whether she ever carries a Sharps container (container to dispose of contaminated needles) when administering injections, RN-C stated she did not, and asked the surveyor whether she should. RN-C was then observed to carry the exposed, contaminated needle and syringe down the hall to the nurse's desk and then appeared to have changed her mind, and turned around and walked all the way down the hall to the medication cart to dispose of the exposed and contaminated needle and syringe. When questioned after she'd disposed of the needle, RN-C verified the exposed needle could	F 441	It is the policy and procedure of Lakeside Medical to follow an infection control program to provide a safe, sanitary and comfortable environment for the residents and to help prevent the development and transmission of disease and infections. Upon facility notification, Employee RN-C was immediately re-educated on proper sharps disposal. The policy for bloodborne pathogens use and disposal of sharps was reviewed and revised. All Nursing staff have been inserviced on proper use and disposal of sharps on 04/08/15. Audits for proper sharps disposal are performed during routine medication pass audits. Results of audits will be reported to facility QAPI committee for identification of patterns or trends. Director of Nursing is Responsible for overall compliance.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 130 have posed a risk to herself and others. During an interview on 4/6/14 at 1:41 p.m., both the assistant administrator and the director of nursing (DON), verified nurses are supposed to have a Sharps container with them, or have the medication cart with Sharps nearby, in order to safely dispose of used needles. They verified the nurse should not have carried the used, exposed needle down the hall. The DON also confirmed the facility's available insulin syringes do not have safety sheaths. The facility policy and procedure Infectious Waste Management, plan revised 10/24/07, directed that used sharps are to be placed directly into rigid, puncture resistant and leak resistant containers that are labeled with a Biohazard symbol and/or the word "Sharps". The facility policy and procedure, Bloodborne Pathogen Exposure Control Plan revised 10/24/07, indicated that Sharps containers are to be taken with the nurse when administering injected medications and the used syringe with the attached needle should be discarded into the container immediately after use.	F 441		
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by:	F 469		5/18/15

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	245374	A. BUILDING _____ B. WING _____	04/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 469	Continued From page 131 Based on observation, interview and document review, the facility failed to provide pest control services for 1 of 1 resident (R49) whose room was observed to have signs of rodents. This had the potential to affect all 31 residents in the facility. Findings include: During an interview on 3/30/15, at 6:56 p.m. family member-I reported mouse droppings in the drawer of R49's desk table in her room. The drawer was opened by family member-I and in th drawer there were opened bags of candy, and what appeared to be mouse droppings. Family member-I stated she had met with various staff about the mouse droppings, and had cleaned the drawer out herself once before. On 3/30/15 at 7:08 p.m., licensed practical nurse (LPN)-C verified that there appeared to be mouse droppings in the drawer. LPN-C put the drawer in a plastic bag and removed it from the room, stating she would have it cleaned. During an interview with the facility's assistant administrator (AA) on 3/30/15 at 8:00 p.m., the AA was made aware of the mouse droppings in R49's desk table in her room. The AA stated the resident's family had brought the desk table in from R49's home but did not know when. During an interview on 3/31/15 at 8:36 a.m., the environmental services director (ESD) stated the facility's pest control company was East Central Exterminating. On 3/31/15, at 10:06 a.m. the ESD stated there was no policy for pest control, but stated East	F 469	It is the policy and procedure of Lakeside Medical to maintain an effective pest program. Exterminator was at facility on 4/2/2015 and no indications of pests or rodents were found. R49□s Desk/dresser was well cleaned inside and out with bleach wipes and food was placed in containers. Resident Council was reminded on 04/14/15 to keep any open foods in containers. Housekeeping, with permission, will check to make sure residents have the containers they need when cleaning rooms. The room cleaning policy was reviewed and revised to include checking for any open food or signs of pest and rodents. Environmental services staff have been educated on updated room cleaning policy. A walk-through of all rooms was performed to check for any open food, or signs of any pests or rodents on 4/14/15. The Environmental Services Supervisor attended a webinar on 04/21/15 titled Rodent Readiness for Food Handling Facilities. The Environmental Services Supervisor or her designee will conduct weekly audits until compliance is reached and quarterly thereafter as needed. The results will be reported to facility QAPI Committee for review of patterns or trends. Environmental services director is responsible for overall compliance.	

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F 469	Continued From page 132 Central Exterminating had been to the facility on 3/19/15. During an interview on 4/1/15, at 1:21 p.m. a representative from East Central Exterminating (ECE)-O stated he had not been made aware of any reports of mouse droppings. During an interview on 4/1/15, at 1:33 p.m. exterminator-N, from East Central Exterminating, stated he inspects areas in the facility such as the entry ways, kitchen, garbage areas and store rooms when he comes monthly, however added that resident room concerns are inspected on an on-call basis. Exterminator-N stated he had not been notified of any concerns in patient rooms recently and verified he had not received any notification of signs of mice this week. Exterminator-N also stated the facility needed a door sweep by the dialysis unit, but stated there had not been an infestation in the facility. Exterminator-N stated he had been at the facility in the middle of March, and in December had set a snap trap, which he only does if droppings are noted. Exterminator-N stated there had been no reports of catching anything from the December traps, but stated he would put out traps again now related to the current concern. A report received from exterminator-N on 4/2/14, indicated 2 black tamper proof boxes with snap traps had been placed in R49's room. The report indicated R49's room was inspected and nothing was found. During environmental rounds with the ESD and the AA on 4/2/15, there were no signs of rodents in R49's room or table/desk drawer. The drawer was found to be clean and tins had been placed	F 469		

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F 469	Continued From page 133 in the drawer for storage of the candy. The facility was unable to provide a policy and procedure for pest control.	F 469		
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the administrator failed to provide adequate supervision of staff and facilty protocols which resulted in an Immediate Jeopardy (IJ) being identified at F333 related to significant medication errors and F425 related to pharmaceutical services. The administrator also failed to ensure residents were appropriately informed of their rights and that resident rights were respected; failed to ensure allegations of abuse were reported and/or investigated appropriately; failed to ensure the building was maintained free of rodents; failed to ensure adequate medical director oversite; and failed to ensure quality assurance (QA) activities identified areas for improvement and action plans to remedy such issues. These administrative failures had the potential to effect 31 of 31 residents at the facility. Findings include: On 3/31/14 the administrator was in the facility and introduced himself to the State Agency. On that same day, at 3:56 p.m., survey staff	F 490	Lakeside Medical is administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. An Interterm Administrator has been hired. The Board of Directors have reviewed all of the documents associated with the survey and approved the plan of correction. The following approaches have been implemented to assure continued compliance. To facilitate a review of processes, Senior Care Solutions, Inc. has been engaged to evaluate current systems and assist with implementation.	5/18/15

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F 490	Continued From page 134 requested an interview with the administrator. The administrator stated he was going to ask the assistant administrator (AA) to come in for the interview as well. The AA entered the room and subsequently responded to all questions during the interview. The questions were related to the facility's protocol for reporting and investigating allegations of abuse. The administrator did not provide any information throughout the interview, but rather sat silently at his desk. During the recertification survey and subsequent IJ investigation, the administrator was not available for questions or concerns. All questions and concerns were directed to the AA. The administrator was not present when survey staff alerted the facility of the IJ situation on 4/2/15 at 5:48 p.m. The administrator was not present for subsequent meetings related to the development and implementation of a removal plan. The administrator was not present when the IJ was removed. Although multiple times were offered for the survey exit meeting, neither the administrator or the AA were present for the survey exit. The Administrator was interviewed by phone on 4/8/15 at 10:30 a.m. He indicated he was at the facility most days for some period of time. The Administrator stated the AA was the, "administrator in training" and "had the reigns." The Administrator stated the AA handled all the issues and was in charge. The Administrator also verified he did not attend the Quality Assurance meetings, but would read the QA minutes and staff would keep him updated about QA activities. In addition the Administrator stated he was aware of the medication errors that had occurred however, stated he had been informed there had not been a pattern identified related to the errors. For specific areas the administration failed to	F 490	The job descriptions of all Department Heads to assure that they reflect accurately assigned responsibilities, especially those noted in this plan. Administrator in consultation with consultant has enhanced QA committee□s quality assurance/QAPI efforts in direct response to survey results, as indicated by each tag. See the individual F-tags for specific description of quality assurance activities.	

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F 490	Continued From page 135 manage appropriately: Refer to F151, F153, F156 related to resident rights issues. Refer to F225 and F226 for abuse policy. Refer to F333 and F425 for significant medication error issues. Refer to F469 for pest control. Refer to F501 for medical director. Refer to F520 for Quality Assurance.	F 490		
F 501 SS=F	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility medical director failed to provide direction, and collaboration with facility staff to address medication administration errors and concerns related to lack of pattern establishment and adequate monitoring of medication administration that had not been addressed. This had the potential to affect all 31 residents who resided in the facility. Findings include: Review of the facility medication incident reports form July 2014 to March of 2015, revealed 7 wrong resident errors, 23 omission errors, 9 wrong dose errors and 5 transcription errors had	F 501	It is the policy of Lakeside Medical Center to have a Medical Director who is responsible for implementation of resident care policies; and the coordination of medical care in the facility. Medication systems changes and revisions to current medication policies and procedures have been approved by facility Medical Director on 4/06/2015. The role of the Medical Director will be reviewed at facility QAPI meeting 5/06/2015. QAPI meeting agenda has been updated to include facility action plans to allow Medical Director to provide feedback and guidance. A monthly report will be sent to	5/18/15

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

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F 501	Continued From page 136 occurred. On 4/7/15, at 2:01 p.m. the medical director was interviewed and verified he attended all the quality assurance (QA) meetings at the facility. He also verified medication incident reports were discussed at the meetings. However, the medical director stated that during the last meeting in January the director of nursing (DON) had attempted to give him a pile of papers on medication errors for his signature. The medical director stated the reports were very unorganized and he was unable to clearly identify or read the errors, potential cause of the errors and/or identify which nurse was responsible for the errors. He verified he had not signed the reports due to the disorganization and had requested the DON to present the information to him in the form of a spreadsheet. He confirmed he was unaware of any patterns occurring in the facility regarding resident medication errors, including wrong resident and omission errors due to the disorganization of the reports. In addition, the medical director stated he was unaware the nurses and trained medication assistants were not being audited following medication errors, nor had any monitoring been implemented to prevent further occurrences. He stated he would expect some sort of monitoring to be in place for the persons making errors, such as routine audits for a period of time. The medical director also stated that during QA meetings there had been no discussion of patterns or root cause in regards to the medication errors, and stated he expected the facility to be proactive in regards to medication administration; identifying patterns of errors if any, and implementing monitoring and corrective action. The medical director stated that no specific concerns had been brought to his	F 501	the Medical Director trends and patterns will be discussed as needed. It will include any trending in care related areas and changes in policies. A medication error log has been revised to track and trend medication errors and the medication error form has been updated to include an investigation and root cause analysis. Interdisciplinary team including Medical Director will have training on QAPI process by contracted Nurse Consultant on 5/6/2015. Meeting will identify quality issues, review for trending and root cause analysis, and will develop appropriate plans of action to correct the quality areas identified by committee. Administrator is responsible for overall compliance.	

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F 501	Continued From page 137 attention by any of the facility's staff members, nurse practioners or physicians regarding medication administration issues.	F 501		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assurance (QA) committee identified quality issues related to medication errors, and develop and implement	F 520	It is the policy of Lakeside Medical Center to have a QAPI committee that meets minimally quarterly to identify issues with respect to quality assessment, assurance	5/18/15

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F 520	Continued From page 138 appropriate plans of actions to correct those quality deficiencies. The QA committee also failed to ensure the social services department addressed resident rights as an ongoing facility practice. This had the potential to affect all 31 residents in the facility. Findings include: During an interview with the assistant administrator (AA) on 4/7/15 at 9:30 a.m., AA indicated the QA committee met quarterly and consisted of herself, department supervisors, the director of nursing, assistant director of nursing, pharmacist and social service designee (SSD). The AA also stated during this interview that pharmacy services and medication errors were discussed at every QA meeting. However, confirmed the QA committee had not identified any trends or the need to develop action plans related to medications errors. The AA stated each medication error had been addressed individually. A telephone interview was conducted with the administrator on 4/8/15 at 2:10 p.m., during the interview the administrator stated he did not attend the QA meetings. During interview with the social service designee (SSD)-A on 4/8/15 at 1:20 p.m., SSD-A stated she attended each QA meeting. She stated each department would bring various topics to the table for discussion. She indicated social services had not brought anything specific to the QA meetings for discussion and verified resident rights had not been discussed at QA meetings. SSD-A indicated resident rights were discussed with residents on admission only.	F 520	and performance improvement. The policy for the QAPI committee was reviewed and revised to include QAPI must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plan for improvement to correct identified quality deficiencies A QAPI meeting will be held on 5/6/2015. QAPI will be meeting monthly for the months of May, June and July of 2015. At the July 2015 meeting the frequency of the ongoing meetings will be reviewed. The committee will receive education from contracted Nurse Consultant on identification of quality issues, identification of patterns and trends, and development of action plans to correct areas identified on 5/6/2015. Administrator is responsible for overall compliance.	

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F 520	Continued From page 139 Refer to F151 related to exercising of resident rights. Refer to F156 related to notification of resident rights. Refer to F250 related to social services. Refer to F333 related to significant medication errors. Refer to F425 related to pharmacy services.	F 520		

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Lakeside Medical Center C & NC was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Lakeside Medical Center C & NC is a 1-story building with a full basement. The original building was constructed in 1966 with an addition constructed in 1971. The 1966 building is of type II(111) construction and the 1971 building is type II(111) construction. Therefore, the nursing home was inspected as one building. The facility has a small hospital and clinic, attached, and they are properly separated from the nursing home. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 46 beds and had a census of 31 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

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

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