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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TJOD

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 **08/07/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathie Siemsen, HFE - NE II 08/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 08/15/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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
07/18/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245374

August 15, 2018

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

Dear Mr. Blaufuss:

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 July 17, 2018 the above facility is recommended 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.

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
August 15, 2018

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

RE: Project Number S5374028 and H5374015

Dear Mr. Blaufuss:

On June 19, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 7, 2018 that included an investigation of complaint number H5374015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 7, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 1, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 7, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 17, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 7, 2018, effective July 17, 2018 and therefore remedies outlined in our letter to you dated June 19, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 15, 2018

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

Re: Reinspection Results - Project Number S5374028 and H5374015

Dear Mr. Blaufuss:

On August 7, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 7, 2018, that included an investigation of complaint number H5374015, with orders received by you on June 19, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TJOD

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Facility ID: 00451

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/07/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

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FISCAL YEAR ENDING DATE: (L35)
09/30

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From (a) :
To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

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

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17. SURVEYOR SIGNATURE Date:
Kathie Siemsen, HFE NE II 06/29/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 07/18/2018 (L20)

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

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

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3. Both of the Above :
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02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
June 19, 2018

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

RE: Project Number S5374028

Dear Mr. Blaufuss:

On June 7, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the June 7, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5374015.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required. In addition, at the time of the June 7, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5374015 that was found to be unsubstantiated.

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

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

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 17, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 17, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

Your ePoC must:

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

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

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

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

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 7, 2018 (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 December 7, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

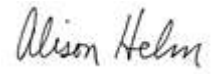
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety

State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	C 06/07/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements was conducted on 6/4/18, through 6/7/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 6/4/18, through 6/7/18, and complaint investigation(s) were also completed at the time of the standard survey. At the time of the survey, an investigation of complaint #H5374015 was completed and was found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of	F 657		7/17/18

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

Electronically Signed | 06/27/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	C 06/07/2018

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 657	Continued From page 1 the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was up to date to reflect current interventions for use of a palm protector for 1 of 1 residents (R9) reviewed for positioning and mobility. Findings include: On 6/4/18, at approximately 6:00 p.m. R9 was observed in bed in her room, with a sheepskin palm protector on the bedside table. R9's fingers were curled tightly into her palms. When asked to straighten her fingers, R9 was able to fully straighten the fingers on her right hand, but could	F 657	F657 R9's palm protector was removed. Hospice updated R9's interventions to include rolled wash cloths to be removed and replaced BID, and the R9's care plan was updated to reflect this change. R9 was assessed on 6/26/18, is not able to fully extend her fingers but functional use remains and is able to grab and hold items. R9 is on Hospice with goal of care being comfort and is not participating in Restorative Nursing due to it causing her discomfort.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	C 06/07/2018

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

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F 657	Continued From page 2 only open the fingers on her left hand about 45 degrees. R9's Admission Record printed 6/6/18, indicated R9 had diagnoses that included Parkinson's disease, and palliative care. R9's significant change Minimum Data Set (MDS) dated 3/13/18, indicated R9 required extensive assistance with personal hygiene. The MDS lacked indication of functional limitation in range of motion (ROM) for R9's wrist/hand. Review of R9's medical record including physician orders, care plan and Kardex lacked written evidence for use of a sheepskin palm protector or any other device to prevent worsening of left hand contracture. On 6/4/18, at approximately 7:00 p.m. R9 was observed to have a sheepskin palm protector in her left hand while she was at an activity in the day room. On 6/4/18, at 7:07 p.m. family member (FM)-A was interviewed and stated R9 had a "Claw thing" going on with her left hand, likely to do with her diagnosis of Parkinson's disease. FM-A stated he didn't know about a sheepskin palm protector being used in R9's left hand. On 6/5/18, at 10:56 a.m. licensed practical nurse (LPN)-C stated she thought perhaps Hospice had implemented the sheepskin palm protector, and confirmed she could not find orders, nor guidance in R9's care plan or Kardex about the sheepskin palm protector. On 6/5/18, at 10:58 a.m. Hospice registered	F 657	All residents have the potential to be affected by this citation. Care plans of all residents were reviewed on 6/29/18 and updated to reflect current needs of care. Staff was educated that they must follow the care plan/Kardex to provide cares/interventions to residents. Any new or changed intervention must be added to the care plan/Kardex at the time of such change. Care plan/Kardex to Care Audits will be completed on 3 residents/week x 1 month, then 2 residents/week x 1 month and then 1 resident/week x 1 month or until 100% compliance is achieved. DON/ Nurse Manager will monitor to ensure compliance and results will be reviewed at monthly QAPI meetings. Compliance will be achieved by 7/17/18.	

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F 657	Continued From page 3	F 657		

nurse (HRN)-A stated she did not implement the sheepskin palm protector for R9, but confirmed R9 had hand contractures. HRN-A stated she implemented an intervention for a rolled washcloth to be used in R9's left hand. HRN-A stated she preferred to use a washcloth, as it could get washed more frequently than a palm protector. HRN-A stated she developed this intervention after surveyor questioning. HRN-A also stated ROM or restorative nursing services would have ended when R9 started hospice services in March, as these movements can cause pain, and R9's goal was comfort cares only.

On 6/5/18, after surveyor questioning, an intervention was added to R9's care plan that directed staff to put a rolled washcloth in R9's left hand, as tolerated, and change with a.m. and p.m. cares to prevent skin breakdown.

On 6/6/18, at 7:23 a.m. nursing assistant (NA)-A entered R9's room to help her get ready for the day. NA-A removed a rolled wash cloth from R9's left hand at that time.

On 6/6/18, from 7:51 a.m. until 8:35 a.m. R9 was observed dressed and sitting in her wheelchair in her room, without a washcloth in her left hand.

On 6/6/18, at 9:07 a.m. R9 was observed in the facility dining room, without a washcloth in her left hand.

On 6/6/18, at 9:23 a.m. NA-A stated she knew to use the rolled washcloth in R9's left hand, as it was written in her Kardex report. NA-A showed where it was listed in the Kardex.

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F 657	Continued From page 4 On 6/6/18, at 11:56 a.m. the director of nursing (DON) stated interventions for ROM restorative nursing services should be in a resident's care plan or Kardex. On 6/6/18, at 1:04 p.m. the DON confirmed the sheepskin palm protector was not in R9's care plan nor in her Kardex. The DON also stated she did not know who started the intervention, or when it was started. On 6/6/18, at 2:26 p.m. the DON stated it was her expectation that interventions be written in the care plan or Kardex so they can be fully implemented. The DON stated she did not know who brought the sheepskin palm protector for R9, and there was no written direction on its use in R9's medical record. The facility's Resident Care Plan and Use of Care Plan policy dated 11/23/17, directed the Interdisciplinary Team Members (IDT) will work directly from the care plan, thereby knowing identified problems, goals and approaches to use.	F 657		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		7/17/18

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F 690	Continued From page 5 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure urinary catheter care was provided for 1 of 1 residents (R29) reviewed for urinary catheter. Findings include: R29's Diagnosis Report dated 6/7/18, indicated diagnoses of palliative care and retention of urine. R29's admission Minimum Data Set (MDS) dated 5/30/18, indicated R29 was cognitively intact and required extensive assistance from staff with toilet use. The MDS also indicated R29 had an	F 690	F690 R29 was assessed on 6/27/18 and does not show any signs/symptoms of UTI. All other residents with indwelling catheters were accessed on6/29/18 for catheter cares and education was provided to ensure compliance of staff with policy. All residents with indwelling catheters have the potential to be affected by this citation. NAR-E and NAR-F were educated	

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F 690	Continued From page 6 indwelling catheter. R29's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 5/23/18, indicated R29 had a urinary catheter in place, and needed extensive assistance with toilet use. The CAA further indicated R29 had a urinary catheter in place due to urinary retention, but failed a voiding exam, therefore the catheter was left in place. The CAA also indicated R29 had declined and was being treated with comfort cares, and the catheter would remain in place. R29's care plan revised on 5/30/18, indicated R29 had an alteration in elimination related to urinary retention and had a catheter. The care plan directed to provide catheter cares per facility policy. On 6/5/18, at 10:40 a.m. R29 was interviewed and stated she did not know why she had a catheter. R29 stated it was put in when she had surgery, and was never removed. On 6/6/18, at 7:40 a.m. R29 was in bed and appeared to be sleeping. The urinary drainage bag was covered, and hanging from the bed frame. At 8:32 a.m. nursing assistant (NA)-E entered R29's room, and asked R29 if she was ready for breakfast. NA-E transferred R29 from the bed to the wheelchair and then to the recliner. R29 then was served breakfast. R29 did not receive catheter care. On 6/7/18, at 8:44 a.m. R29's cares were observed provided by nursing assistant (NA)-F. R29 was in bed wearing a night gown. NA-F raised the head of the bed, removed a pillow from under R29's knees and sat R29 on the edge of	F 690	regarding catheter care expectations on 6/27/18. Nursing staff was educated on 6/27/18 regarding policy and expectation that catheter cares are to be provided to all residents with indwelling catheters qAM and qHS with cares to prevent the potential of UTI. Indwelling Cather Care Audits will be completed on 3 residents/week x 1 month, then 2 residents/week x 1 month and then 1 resident/week x 1 month or until 100% compliance is achieved. DON/ Nurse Manager will monitor to ensure compliance and results will be reviewed at monthly QAPI meetings. Compliance will be achieved by 7/17/18	

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F 690	Continued From page 7	F 690		

the bed. R29 complained of pain where a drain tube was inserted. NA-F called for the nurse. Licensed practical nurse (LPN)-B came in and assessed R29's pain. LPN-B then called for the nurse practitioner (NP). The NP entered and assessed R29's pain. After the LPN and the NP exited, NA-F checked R29's incontinent brief, then stated it looked fine and did not need to be changed. Catheter care was not provided. NA-F applied R29's pants, sat R29 up on the edge of the bed, put on R29's shoes, and applied the transfer belt. NA-F stood R29 up, pulled up R29's pants and transferred R29 into the wheelchair. NA-F brought R29 into the bathroom, and removed the transfer belt and the night gown. NA-F handed R29 a washcloth. R29 washed her face, hands and under her arms. NA-F washed R29's back and under her abdomen. NA-F applied R29's bra, shirt, and sweater, and applied lotion to R29's back. NA-F offered R29 the toilet. R29 declined, and stated maybe after breakfast. After R29 brushed her teeth, she was moved in front of the television with a tray table in front of her. NA-F exited R29's room at 10:00 a.m. Catheter care was not provided. At 10:12 a.m. NA-F returned and served R29 toast and coffee. At 10:20 a.m. R29 put on the call light and requested to go to a beauty shop appointment. At 10:25 a.m. R29 was transported to the beauty shop. At 11:28 a.m. R29 returned from the beauty shop. NA-F entered R29's room and transferred R29 from the wheelchair to the bed. NA-F moved the urinary drainage bag from the wheelchair to the bed frame, and placed a pillow under R29's legs. R29 declined lunch until later. At 11:40 a.m. R29 stated she did not use the bathroom while in the beauty shop. At 12:25 p.m. R29 put on the call light and requested something to eat. At 12:34 p.m. LPN-B brought R29 her lunch. R29

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F 690	Continued From page 8 was then transferred to the wheelchair and provided lunch. Catheter care was not provided. On 6/7/18, at 1:21 p.m. NA-F stated she did not usually do R29's cares and usually worked as an activity aide, but got called in to work as a nursing assistant. NA-F stated she was working 8:00 a.m. to 2:40 p.m., and it was noted on her sheet that NA-E provided care at 7:28 a.m. NA-F stated it did not specify what cares NA-E provided. NA-F stated she just emptied R29's urinary drainage bag, and she did not provide catheter care because R29 did not request to have a bowel movement. NA-F stated that was when she usually provided catheter care for R29. On 6/7/18, at 1:24 p.m. NA-E stated at 7:28 a.m. she checked R29's incontinent brief and it was dry. NA-E verified she did not provide catheter care to R29. On 6/7/18, at approximately 2:30 p.m. the director of nursing (DON) stated she would expect catheter care to be done during morning and evening cares. The DON stated this should be done for anyone with a catheter, and should not wait until a resident had a bowel movement. The facility's Routine Catheter Care policy dated 6/12/02, directed the purpose of catheter care was to decrease the potential of infection.	F 690		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include,	F 758		7/17/18

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F 758	Continued From page 9 but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic	F 758		

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F 758	Continued From page 10 drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the effectiveness of as needed antipsychotic medications were documented for 1 of 5 residents (R21) reviewed for unnecessary medications. Findings include: R21's Diagnosis Report dated 6/7/18, indicated diagnoses of vascular dementia with behavioral disturbance, Alzheimer's disease, psychotic disorder with hallucinations due to a known physiological condition, conduct disorder, delusional disorder, depression, and anxiety. R21's quarterly Minimum Data Set (MDS) dated 5/5/18, indicated R21 had severely impaired cognition. The MDS idfentified R21 had not had any hallucinations or behaviors in the look back period. The MDS indicated R29 had rejected care on one to three days during the assessment period. The MDS further indicated R21 received antipsychotic, antidepressant, diuretic, and opioid medication on seven of seven days during the assessment period. The antipsychotic was received on a routine basis, and a gradual dose reduction was attempted. R21's care plan dated 2/6/18, indicated R21 had the potential for side effects related to psychotropic medication use secondary to psychotic disorder, depression, anxiety,	F 758	F758 R21 was assessed on 6/27/18 and no ill effects were noted. All resident MARs were reviewed for PRN psychotropic medication follow up and any discrepancies were corrected. All residents receiving PRN Psychotropic medications have the potential to be affected by this citation. TMA's and licensed nurses were re-educated on 6/27/18 regarding the expectation that PRN psychotropic medication, when administered, must have the effectiveness/response to med evaluated and result documented on the backside of the MAR. PRN Psychotropic Med Documentation Audits will be done on residents who receive PRN Psychotropic Medications on 4 residents/week x 1 month, then 3 residents/week x 1 month and then 2 residents/week x 1 month or until 100% compliance is achieved. DON/ Nurse Manager will monitor to ensure compliance and results will be reviewed at monthly QAPI meetings. Compliance will be achieved by 7/17/18	

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hallucinations and insomnia. The care plan directed to provide medications as ordered, and complete psychotropic monitoring per facility policy. The care plan further directed to document as needed clinical indications and effectiveness of the medication on the back of the medication administration record. R21's target behaviors included self isolation, anxiousness, yelling, elopement, aggression, foul language/cursing, ignoring staff, refusal of cares, hitting staff and residents. Interventions included one to one approach, a calm approach, contact with family, assist to room, monitor whereabouts during behavior outbreaks to ensure safety of others, explain task, reapproach and monitor the percentage of sleep.

R21's Physician's Orders included the following orders:
On 3/22/18, Haldol (an antipsychotic medication) 0.5 milligrams (mg) by mouth or intramuscular (IM, an injection into the muscle) every eight hours as needed for severe agitation, delusions causing distress or risk of harm to R21, and to reassess in 14 days.
On 3/27/18, continue as needed Haldol 0.5 mg by mouth or IM every eight hours as needed for agitation/anxiety causing distress to R21.
On 4/10/18, resume Haldol 0.5 mg by mouth or IM every eight hours as needed for severe agitation/anxiety causing distress to R21. Will reassess in two weeks.
On 4/24/18, resume Haldol 0.5 mg by mouth or IM every eight hours as needed for severe agitation/anxiety causing distress to R21.
On 5/2/18, Haldol 2.5 mg IM one time now. May repeat in 45 minutes one time if not calmed for psychosis, eloping risk and hallucinations. Send to the emergency department if second dose

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ineffective for closer monitoring.
On 5/3/18, change as needed Haldol to 1 mg by mouth or IM every six hours. OK to repeat if not effective after one hour, and give an additional 1 mg by mouth or IM. Continue to use distraction techniques as first line, and utilize medication when unable to calm R21's agitation, delusions and distress.
On 5/13/18, continue as needed Haldol for two weeks.
On 5/31/18, continue previous Haldol as needed order for 14 days.

R21's Medication Administration Record (MAR) dated 3/1/18, through 3/31/18, indicated R21 received Haldol 0.5 mg by mouth at 4:28 p.m. on 3/22/18, and at 8:30 a.m. on 3/26/18, for agitation and distress. R21's MAR and progress notes lacked the effectiveness of the as needed Haldol.

R21's MAR dated 4/1/18, through 4/30/18, indicated R21 received Haldol 0.5 mg by mouth 20 times. R21's MAR and progress notes lacked the effectiveness of the as needed Haldol five times.

R21's MAR dated 5/1/18, through 5/31/18, indicated R21 received Haldol 0.5 mg by mouth 14 times. R21's MAR and progress notes lacked the effectiveness of the as needed Haldol two times. In addition, R21 received Haldol 2.5 mg IM one time on 5/2/18. R21's MAR and progress notes lacked the effectiveness of the IM Haldol.

On 6/5/18, at 3:48 p.m. R21 was observed in her room in the recliner. The television was on, and R21 appeared to be sleeping.

On 6/6/18, at 7:36 a.m. R21 was observed in her

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room sitting in the wheelchair covered with a blanket. The television was on, and R21 appeared to be sleeping.

On 6/6/18, at 9:16 a.m. activity staff was observed asking R 21 if she wanted to play cards and games. R21 declined and stated she was going somewhere. R21 remained in her room.

On 6/6/18, at 1:59 p.m. R21 was observed propelling her wheelchair in the hall. R21 stated she was looking for a boy. Staff asked R21 if she wanted to go to a painting activity. R21 declined and returned to her room.

On 6/7/18, at 1:08 p.m. licensed practical nurse (LPN)-C stated the reason for giving an as needed medication, and the effectiveness of the as needed medications were recorded on the back of the MAR. LPN-C stated would document the reason the as needed medication was given, and describe the behavior in the progress notes. LPN-C further stated R 21 would get distressed, and wants to go outside. LPN-C verified the MAR lacked the effectiveness of the as needed medications, and stated the effectiveness should be noted on the back of the MAR, or in the progress notes.

On 6/7/18, at approximately 2:00 p.m. the director of nursing (DON) stated she would expect staff to document the effectiveness of as needed medications on the MAR or in a nurses note. The DON stated there were tabs in the MAR to pull out to remind them staff there needed to be a follow up on an as needed medication, and there was a process in place.

The facility's Medication Administration policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	C 06/07/2018

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 758	Continued From page 14 dated 2/22/18, directed when an as needed medication was administered the effectiveness was to be documented.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medication labels provided the current directions for use for 2 of 6 residents (R29, R21) reviewed for medication administration. In addition, the facility failed to	F 761	F761 R29 and R21 received the correct medication dosages as ordered by MD.	7/17/18

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F 761	Continued From page 15 ensure controlled medications were properly disposed of following compromise of the secure seal of the unit dose packaging to prevent diversion for 2 of 15 residents (R2, R7) who received controlled medications. Findings include: R29's Admission Record printed 6/5/18, indicated R29's diagnoses included osteoarthritis and pain in the right shoulder. R29's signed Physician Orders dated 5/15/18, included orders for acetaminophen (pain reliever) 1000 milligrams (mg) by mouth three time daily and 500 mg by mouth twice daily as needed for pain with a maximum of 4000 mg/24 hours. R29's Medication Administration Record (MAR) for June 2018, indicated R29 was to receive acetaminophen 1000 mg three times daily and 500 mg twice daily as needed with a maximum of 4000 mg in 24 hours. On 6/4/18, at 4:36 p.m. registered nurse (RN)-A prepared R29's medication for administration. R29's medication card label for for acetaminophen directed R29 was to receive two 500 mg tablets (1000 mg) four times daily and one 500 mg tablet twice daily as needed for pain or fever. R29 received the medication as the physician ordered it. On 6/4/18, at 6:00 p.m. RN-A verified the medication label for R29's acetaminophen was wrong, and if R29 had taken 1000 mg four times daily and 500 mg twice daily, R29 would have received more than 4000 mg of acetaminophen in 24 hours. RN-A put a "Directions changed refer to	F 761	All residents receiving medications have the potential to be affected by this citation. 100% Audit, completed on 6/27/18 of all resident's meds compared to MD order to ensure med label matched MD order and that all controlled med cards were intact and no meds were taped in place. Any discrepancies noted were corrected. TMA's and licensed nurses were re-educated on 6/27/18 regarding the expectation that MD order for medication must match the medication label, if there is a change in orders and the med card will continue to be utilized, a "Directions Changed" sticker must be added to the label/card to alert staff that a change has occurred. TMA's and licensed nurses were also re-educated on 6/27/18 regarding the requirement that whenever a controlled medication is removed from the med card and subsequently not administered to the resident OR if the integrity of the med card packaging is compromised, the controlled substance affected must be destroyed via 1 RN and 1 RN/LPN/TMA and documented as such. Medication Order to Med Label Audits will be done on 5 residents/week x 1 month, then 3 residents/week x 1 month and then 2 residents/week x 1 month or until 100% compliance is achieved and Controlled Medication Packaging Integrity/Destruction Audits will be done weekly x 3 months or until 100% compliance is achieved. DON/ Nurse Manager will monitor and to ensure compliance and results will be reviewed at	

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F 761	Continued From page 16 chart" sticker on the medication card label. R21's Diagnosis Report printed 6/5/18, indicated R21's diagnoses included major depressive disorder, insomnia, and dementia with behavioral disturbance. R21's signed Physician's Orders dated 5/31/18, included an order for Trazodone (antidepressant) 25 mg by mouth every p.m. for insomnia and anxiety. R21's MAR for May and June 2018, indicated R21 was to receive Trazodone 25 mg by mouth every p.m. for insomnia and anxiety. On 6/4/18, at 5:16 p.m. trained medication aide (TMA)-D prepared R21's medications for administration. R21's medication card label for Trazodone 50 mg tablets, directed R21 to receive 1/2 tablet (25 mg) by mouth daily at 5 p.m. and 1/2 tablet (25 mg) by mouth every bedtime as needed (prn) for insomnia and anxiety. TMA-D administered R21's Trazodone as the physician had ordered it. On 6/4/18, at 6:14 p.m. the director of nursing (DON) verified R21 did not have an order to administer a prn dose of Trazodone, and was to have a scheduled dose of Trazodone 25 mg only, and stated the label was wrong. The DON stated R21 had not received a prn dose of Trazodone. The DON put a "Directions changed refer to chart" sticker on R21's medication card for Trazodone. On 6/5/18, at 12:17 p.m. the DON stated the medication nurse should look at the labels with medication administration, and put a change in	F 761	monthly QAPI meetings. Compliance will be achieved by 7/17/18	

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F 761	Continued From page 17 direction sticker on the card as necessary. The facility policy and procedure for Medication Labels Changes dated 12/16, directed nursing to identify the medication container with an auxiliary label such as "Directions changed refer to chart" when the directions for use and/or dosage of the medication has changed, and the pharmacy should be notified of all new orders. R2's Admission Record printed 6/5/18, indicated R2's diagnoses included osteoarthritis. R2's signed Physician's Orders dated 5/31/18, included an order for oxycodone (narcotic pain medication) immediate release 5 mg one tablet by mouth every 6 hours as needed for severe pain. On 6/5/18, at 9:46 a.m. during an audit of controlled narcotic medications, R2's oxycodone medication card had 41 tablets in the medication card, but tablet #41 had been opened in the back of the card and had a piece of tape over it, to hold the tablet in. There was also a piece of tape over #46, which had been used previously. R7's Admission Record printed 6/5/18, indicated R7's diagnoses included chronic pain syndrome. R7's Physician's Orders dated 5/31/18, included an order for hydromorphone (narcotic pain medication) 1 mg twice daily as needed. On 6/5/18, at 9:46 a.m. during an audit of controlled narcotic medications, R7's hydromorphone medication card had 49 half tablets in the medication card, but tablet #50 had been opened in the back of the card, and had a	F 761		

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F 761	Continued From page 18 piece of tape over it to hold the tablet in. On 6/5/18, at 9:46 a.m. licensed practical nurse (LPN)-C stated medications should not be taped back in the medication card, and should be destroyed with two staff by flushing in the sewer. On 6/5/18 at 9:57 a.m. licensed practical nurse LPN-B stated she would re-tape the medication into the card if there was just a small hold punched in the card, but if it were punched through, she would destroy the medication. On 6/5/18, at 12:17 p.m. the DON stated if medications are altered in anyway, they should be destroyed. The DON stated if the medication was punched out on the medication card, it would need to be wasted according to the facility policy. The facility policy and procedure for Controlled Medications Administration dated 12/16, lacked direction for management of controlled medications when the seal had been compromised and opened.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		7/17/18

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F 880	Continued From page 19 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 20 by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was completed following a blood glucose check to prevent cross contamination for 1 of 2 residents (R6) observed during a blood glucose check. Findings include: R6's Admission Record printed 6/5/18, indicated R6's diagnoses included Diabetes Mellitus type 2. R6's signed Physician Orders dated 5/31/18, directed blood glucose checks to be done twice daily. On 6/4/18, at 4:34 p.m. registered nurse (RN)-A was observed to prepare to check R6's blood glucose. RN-A brought the supply cart into R6's room. RN-A sanitized her hands, donned gloves, set up supplies, cleansed R6's third left finger with an alcohol wipe, and poked R6's finger with the lancet. RN-A obtained the blood sample in the	F 880	F880 R6 was assessed and was not affected by RN-A not washing hands after glove removal after blood sugar check was already completed. All residents requiring blood sugar checks have the potential to be affected by this citation. Other nurses were audited on blood sugar checks and any discrepancies were corrected and education provided. RN-A was re-educated on 6/19/18 and all nurses were re-educated on 6/27/18 regarding the requirement to wash hands immediately after glove removal following blood sugar checks before moving to the next task to prevent cross contamination and potential infection. Glucometer/Hand Hygiene Audits will be	

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F 880	Continued From page 21 test strip inserted in the glucometer (hand-held blood glucose monitoring machine), read the result, and removed the test strip from the glucometer with her gloved hand. RN-A wiped off the glucometer with an alcohol swab, wrapped the glucometer in an antibacterial/disinfectant sani-wipe, set it on the cart, and removed her gloves. RN-A pushed the cart out of R6's room, closed the door, and sanitized her hands. On 6/4/18, at 4:46 p.m. RN-A stated she would normally wash or sanitize her hands immediately after removing her gloves ,and again after leaving the resident's room. RN-A then washed her hands in the medication room. RN-A verified she pushed the diabetic supply cart out the door and closed the door before sanitizing her hands. On 6/5/18, at 12:17 p.m. director of nursing (DON) verified nursing should wash or sanitize their hands after removing gloves or moving from task to task. The facility policy and procedure for Hand Hygiene undated, directed staff to perform hand hygiene (hand washing, antiseptic hand wash or antiseptic hand rub) after touching body fluids, and immediately after removing gloves. The facility policy and procedure for Accucheck Blood Glucose Monitoring dated 6/14, directed staff to wash hands prior to donning gloves and beginning the blood glucose check, and after removing gloves following the wrapping of the glucometer in the disinfectant product.	F 880	done 3x/week x 1 month, then 2x/week x 1 month and then 1x/week x 1 month or until 100% compliance is achieved. DON/ Nurse Manager will monitor to ensure compliance and results will be reviewed at monthly QAPI meetings. Compliance will be achieved by 7/17/18	

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	245374	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY Building 01 - Main Building: THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Lakeside Medical Center C & NC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/20/2018

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

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K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lakeside 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	K 000		

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K 000	Continued From page 2 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 34 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT met.	K 000		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 46 of 46 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 901	Risk assessment for basic care and support care rooms was done on 6/13/18. All rooms assessed for risk of harm to residents due to loss of utilities. Assessment added to yearly maintenance inspection list to ensure completion. Jaime Burg performed correction. Jaime Burg EVS will be responsible for monitoring to prevent reoccurrence of the deficiency.	6/13/18

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K 901	Continued From page 3 On facility tour between 11:00 a.m. to 2:00 p.m. on 06/06/2018, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility's could not provide a completed facility risk assessment document at the time of the inspection. This deficient condition was confirmed by a Maintenance Supervisor.	K 901		

Electronically delivered
June 19, 2018

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

Re: State Nursing Home Licensing Orders - Project Numbers S5374028 and H5374015

Dear Mr. Blaufuss:

The above facility was surveyed on June 4, 2018 through June 7, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5374015 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

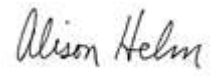
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Teresa Ament, Unit Supervisor at (218) 302-6151 or teresa.ament@state.mn.us.

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

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

Please feel free to call me with any questions.



Alison Helm, Enforcement Specialist
Licensing and Certification
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cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00451	A. BUILDING: _____ B. WING _____	C 06/07/2018

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) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 6/4/18, through 6/7/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. H Complaint H5374015 was investigated and not substantiated. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES,	2 000		

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2 000	Continued From page 2 "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was up to date to reflect current interventions for use of a palm protector for 1 of 1 residents (R9) reviewed for positioning and mobility. Findings include: On 6/4/18, at approximately 6:00 p.m. R9 was observed in bed in her room, with a sheepskin palm protector on the bedside table. R9's fingers were curled tightly into her palms. When asked to	2 570	corrected	7/17/18

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2 570	Continued From page 3	2 570		

straighten her fingers, R9 was able to fully straighten the fingers on her right hand, but could only open the fingers on her left hand about 45 degrees.

R9's Admission Record printed 6/6/18, indicated R9 had diagnoses that included Parkinson's disease, and palliative care.

R9's significant change Minimum Data Set (MDS) dated 3/13/18, indicated R9 required extensive assistance with personal hygiene. The MDS lacked indication of functional limitation in range of motion (ROM) for R9's wrist/hand.

Review of R9's medical record including physician orders, care plan and Kardex lacked written evidence for use of a sheepskin palm protector or any other device to prevent worsening of left hand contracture.

On 6/4/18, at approximately 7:00 p.m. R9 was observed to have a sheepskin palm protector in her left hand while she was at an activity in the day room.

On 6/4/18, at 7:07 p.m. family member (FM)-A was interviewed and stated R9 had a "Claw thing" going on with her left hand, likely to do with her diagnosis of Parkinson's disease. FM-A stated he didn't know about a sheepskin palm protector being used in R9's left hand.

On 6/5/18, at 10:56 a.m. licensed practical nurse (LPN)-C stated she thought perhaps Hospice had implemented the sheepskin palm protector, and confirmed she could not find orders, nor guidance in R9's care plan or Kardex about the sheepskin palm protector.

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2 570	Continued From page 4 On 6/5/18, at 10:58 a.m. Hospice registered nurse (HRN)-A stated she did not implement the sheepskin palm protector for R9, but confirmed R9 had hand contractures. HRN-A stated she implemented an intervention for a rolled washcloth to be used in R9's left hand. HRN-A stated she preferred to use a washcloth, as it could get washed more frequently than a palm protector. HRN-A stated she developed this intervention after surveyor questioning. HRN-A also stated ROM or restorative nursing services would have ended when R9 started hospice services in March, as these movements can cause pain, and R9's goal was comfort cares only. On 6/5/18, after surveyor questioning, an intervention was added to R9's care plan that directed staff to put a rolled washcloth in R9's left hand, as tolerated, and change with a.m. and p.m. cares to prevent skin breakdown. On 6/6/18, at 7:23 a.m. nursing assistant (NA)-A entered R9's room to help her get ready for the day. NA-A removed a rolled wash cloth from R9's left hand at that time. On 6/6/18, from 7:51 a.m. until 8:35 a.m. R9 was observed dressed and sitting in her wheelchair in her room, without a washcloth in her left hand. On 6/6/18, at 9:07 a.m. R9 was observed in the facility dining room, without a washcloth in her left hand. On 6/6/18, at 9:23 a.m. NA-A stated she knew to use the rolled washcloth in R9's left hand, as it was written in her Kardex report. NA-A showed where it was listed in the Kardex.	2 570		

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2 570	Continued From page 5 On 6/6/18, at 11:56 a.m. the director of nursing (DON) stated interventions for ROM restorative nursing services should be in a resident's care plan or Kardex. On 6/6/18, at 1:04 p.m. the DON confirmed the sheepskin palm protector was not in R9's care plan nor in her Kardex. The DON also stated she did not know who started the intervention, or when it was started. On 6/6/18, at 2:26 p.m. the DON stated it was her expectation that interventions be written in the care plan or Kardex so they can be fully implemented. The DON stated she did not know who brought the sheepskin palm protector for R9, and there was no written direction on its use in R9's medical record. The facility's Resident Care Plan and Use of Care Plan policy dated 11/23/17, directed the Interdisciplinary Team Members (IDT) will work directly from the care plan, thereby knowing identified problems, goals and approaches to use. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the revision of the care plan. The DON or designee, could provide training for all nursing staff related to care plan revision. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence	2 910		7/17/18

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2 910	Continued From page 6 Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure urinary catheter care was provided for 1 of 1 residents (R29) reviewed for urinary catheter. Findings include: R29's Diagnosis Report dated 6/7/18, indicated diagnoses of palliative care and retention of urine. R29's admission Minimum Data Set (MDS) dated 5/30/18, indicated R29 was cognitively intact and required extensive assistance from staff with toilet use. The MDS also indicated R29 had an indwelling catheter. R29's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 5/23/18, indicated R29 had a urinary catheter in	2 910	corrected	

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2 910	Continued From page 7	2 910		

place, and needed extensive assistance with toilet use. The CAA further indicated R29 had a urinary catheter in place due to urinary retention, but failed a voiding exam, therefore the catheter was left in place. The CAA also indicated R29 had declined and was being treated with comfort cares, and the catheter would remain in place.

R29's care plan revised on 5/30/18, indicated R29 had an alteration in elimination related to urinary retention and had a catheter. The care plan directed to provide catheter cares per facility policy.

On 6/5/18, at 10:40 a.m. R29 was interviewed and stated she did not know why she had a catheter. R29 stated it was put in when she had surgery, and was never removed.

On 6/6/18, at 7:40 a.m. R29 was in bed and appeared to be sleeping. The urinary drainage bag was covered, and hanging from the bed frame. At 8:32 a.m. nursing assistant (NA)-E entered R29's room, and asked R29 if she was ready for breakfast. NA-E transferred R29 from the bed to the wheelchair and then to the recliner. R29 then was served breakfast. R29 did not receive catheter care.

On 6/7/18, at 8:44 a.m. R29's cares were observed provided by nursing assistant (NA)-F. R29 was in bed wearing a night gown. NA-F raised the head of the bed, removed a pillow from under R29's knees and sat R29 on the edge of the bed. R29 complained of pain where a drain tube was inserted. NA-F called for the nurse. Licensed practical nurse (LPN)-B came in and assessed R29's pain. LPN-B then called for the nurse practitioner (NP). The NP entered and assessed R29's pain. After the LPN and the NP

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2 910	Continued From page 8	2 910		

exited, NA-F checked R29's incontinent brief, then stated it looked fine and did not need to be changed. Catheter care was not provided. NA-F applied R29's pants, sat R29 up on the edge of the bed, put on R29's shoes, and applied the transfer belt. NA-F stood R29 up, pulled up R29's pants and transferred R29 into the wheelchair. NA-F brought R29 into the bathroom, and removed the transfer belt and the night gown. NA-F handed R29 a washcloth. R29 washed her face, hands and under her arms. NA-F washed R29's back and under her abdomen. NA-F applied R29's bra, shirt, and sweater, and applied lotion to R29's back. NA-F offered R29 the toilet. R29 declined, and stated maybe after breakfast. After R29 brushed her teeth, she was moved in front of the television with a tray table in front of her. NA-F exited R29's room at 10:00 a.m. Catheter care was not provided. At 10:12 a.m. NA-F returned and served R29 toast and coffee. At 10:20 a.m. R29 put on the call light and requested to go to a beauty shop appointment. At 10:25 a.m. R29 was transported to the beauty shop. At 11:28 a.m. R29 returned from the beauty shop. NA-F entered R29's room and transferred R29 from the wheelchair to the bed. NA-F moved the urinary drainage bag from the wheelchair to the bed frame, and placed a pillow under R29's legs. R29 declined lunch until later. At 11:40 a.m. R29 stated she did not use the bathroom while in the beauty shop. At 12:25 p.m. R29 put on the call light and requested something to eat. At 12:34 p.m. LPN-B brought R29 her lunch. R29 was then transferred to the wheelchair and provided lunch. Catheter care was not provided.

On 6/7/18, at 1:21 p.m. NA-F stated she did not usually do R29's cares and usually worked as an activity aide, but got called in to work as a nursing assistant. NA-F stated she was working 8:00 a.m.

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2 910	Continued From page 9	2 910		

to 2:40 p.m., and it was noted on her sheet that NA-E provided care at 7:28 a.m. NA-F stated it did not specify what cares NA-E provided. NA-F stated she just emptied R29's urinary drainage bag, and she did not provide catheter care because R29 did not request to have a bowel movement. NA-F stated that was when she usually provided catheter care for R29.

On 6/7/18, at 1:24 p.m. NA-E stated at 7:28 a.m. she checked R29's incontinent brief and it was dry. NA-E verified she did not provide catheter care to R29.

On 6/7/18, at approximately 2:30 p.m. the director of nursing (DON) stated she would expect catheter care to be done during morning and evening cares. The DON stated this should be done for anyone with a catheter, and should not wait until a resident had a bowel movement.

The facility's Routine Catheter Care policy dated 6/12/02, directed the purpose of catheter care was to decrease the potential of infection.

SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure residents with catheters received appropriate care and services. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21385	Continued From page 10	21385		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure proper hand hygiene was completed following a blood glucose check to prevent cross contamination for 1 of 2 residents (R6) observed during a blood glucose check. Findings include: R6's Admission Record printed 6/5/18, indicated R6's diagnoses included Diabetes Mellitus type 2. R6's signed Physician Orders dated 5/31/18, directed blood glucose checks to be done twice daily. On 6/4/18, at 4:34 p.m. registered nurse (RN)-A was observed to prepare to check R6's blood glucose. RN-A brought the supply cart into R6's room. RN-A sanitized her hands, donned gloves, set up supplies, cleansed R6's third left finger with an alcohol wipe, and poked R6's finger with the lancet. RN-A obtained the blood sample in the test strip inserted in the glucometer (hand-held blood glucose monitoring machine), read the result, and removed the test strip from the glucometer with her gloved hand. RN-A wiped off	21385	corrected	7/17/18

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21385	Continued From page 11	21385		

the glucometer with an alcohol swab, wrapped the glucometer in an antibacterial/disinfectant sani-wipe, set it on the cart, and removed her gloves. RN-A pushed the cart out of R6's room, closed the door, and sanitized her hands.

On 6/4/18, at 4:46 p.m. RN-A stated she would normally wash or sanitize her hands immediately after removing her gloves ,and again after leaving the resident's room. RN-A then washed her hands in the medication room. RN-A verified she pushed the diabetic supply cart out the door and closed the door before sanitizing her hands.

On 6/5/18, at 12:17 p.m. director of nursing (DON) verified nursing should wash or sanitize their hands after removing gloves or moving from task to task.

The facility policy and procedure for Hand Hygiene undated, directed staff to perform hand hygiene (hand washing, antiseptic hand wash or antiseptic hand rub) after touching body fluids, and immediately after removing gloves.

The facility policy and procedure for Accucheck Blood Glucose Monitoring dated 6/14, directed staff to wash hands prior to donning gloves and beginning the blood glucose check, and after removing gloves following the wrapping of the glucometer in the disinfectant product.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing, infection preventionist, or designee could develop, review, and/or revise policies and procedures to ensure proper hand hygiene practices following blood glucose monitoring.
The Director of Nursing and infection preventionist or designee could educate all

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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) COMPLETE DATE
21385	Continued From page 12 appropriate staff on the policies and procedures. The Director of Nursing and infection preventionist or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21385		
21585	MN Rule 4658.1325 Subp. 8 Administration of Medications; documentation Subp. 8. Documentation of administration. The name, date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized person who administered and observed the same must be recorded in the resident's clinical record. Documentation of the administration must take place following the administration of the medication. If administration of the medication was not completed as prescribed, the documentation must include the reason the administration was not completed, and the follow-up that was provided, such as notification of a registered nurse or the resident's attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the effectiveness of as needed antipsychotic medications were documented for 1 of 5 residents (R21) reviewed for unnecessary medications. Findings include:	21585	corrected	7/17/18

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R21's Diagnosis Report dated 6/7/18, indicated diagnoses of vascular dementia with behavioral disturbance, Alzheimer's disease, psychotic disorder with hallucinations due to a known physiological condition, conduct disorder, delusional disorder, depression, and anxiety.

R21's quarterly Minimum Data Set (MDS) dated 5/5/18, indicated R21 had severely impaired cognition. The MDS idfentified R21 had not had any hallucinations or behaviors in the look back period. The MDS indicated R29 had rejected care on one to three days during the assessment period. The MDS further indicated R21 received antipsychotic, antidepressant, diuretic, and opioid medication on seven of seven days during the assessment period. The antipsychotic was received on a routine basis, and a gradual dose reduction was attempted.

R21's care plan dated 2/6/18, indicated R21 had the potential for side effects related to psychotropic medication use secondary to psychotic disorder, depression, anxiety, hallucinations and insomnia. The care plan directed to provide medications as ordered, and complete psychotropic monitoring per facility policy. The care plan further directed to document as needed clinical indications and effectiveness of the medication on the back of the medication administration record. R21's target behaviors included self isolation, anxiousness, yelling, elopement, aggression, foul language/cursing, ignoring staff, refusal of cares, hitting staff and residents. Interventions included one to one approach, a calm approach, contact with family, assist to room, monitor whereabouts during behavior outbreaks to ensure safety of others, explain task, reapproach and monitor the percentage of sleep.

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21585	Continued From page 14 R21's Physician's Orders included the following orders: On 3/22/18, Haldol (an antipsychotic medication) 0.5 milligrams (mg) by mouth or intramuscular (IM, an injection into the muscle) every eight hours as needed for severe agitation, delusions causing distress or risk of harm to R21, and to reassess in 14 days. On 3/27/18, continue as needed Haldol 0.5 mg by mouth or IM every eight hours as needed for agitation/anxiety causing distress to R21. On 4/10/18, resume Haldol 0.5 mg by mouth or IM every eight hours as needed for severe agitation/anxiety causing distress to R21. Will reassess in two weeks. On 4/24/18, resume Haldol 0.5 mg by mouth or IM every eight hours as needed for severe agitation/anxiety causing distress to R21. On 5/2/18, Haldol 2.5 mg IM one time now. May repeat in 45 minutes one time if not calmed for psychosis, eloping risk and hallucinations. Send to the emergency department if second dose ineffective for closer monitoring. On 5/3/18, change as needed Haldol to 1 mg by mouth or IM every six hours. OK to repeat if not effective after one hour, and give an additional 1 mg by mouth or IM. Continue to use distraction techniques as first line, and utilize medication when unable to calm R21's agitation, delusions and distress. On 5/13/18, continue as needed Haldol for two weeks. On 5/31/18, continue previous Haldol as needed order for 14 days. R21's Medication Administration Record (MAR) dated 3/1/18, through 3/31/18, indicated R21 received Haldol 0.5 mg by mouth at 4:28 p.m. on 3/22/18, and at 8:30 a.m. on 3/26/18, for agitation	21585		

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and distress. R21's MAR and progress notes lacked the effectiveness of the as needed Haldol.

R21's MAR dated 4/1/18, through 4/30/18, indicated R21 received Haldol 0.5 mg by mouth 20 times. R21's MAR and progress notes lacked the effectiveness of the as needed Haldol five times.

R21's MAR dated 5/1/18, through 5/31/18, indicated R21 received Haldol 0.5 mg by mouth 14 times. R21's MAR and progress notes lacked the effectiveness of the as needed Haldol two times. In addition, R21 received Haldol 2.5 mg IM one time on 5/2/18. R21's MAR and progress notes lacked the effectiveness of the IM Haldol.

On 6/5/18, at 3:48 p.m. R21 was observed in her room in the recliner. The television was on, and R21 appeared to be sleeping.

On 6/6/18, at 7:36 a.m. R21 was observed in her room sitting in the wheelchair covered with a blanket. The television was on, and R21 appeared to be sleeping.

On 6/6/18, at 9:16 a.m. activity staff was observed asking R 21 if she wanted to play cards and games. R21 declined and stated she was going somewhere. R21 remained in her room.

On 6/6/18, at 1:59 p.m. R21 was observed propelling her wheelchair in the hall. R21 stated she was looking for a boy. Staff asked R21 if she wanted to go to a painting activity. R21 declined and returned to her room.

On 6/7/18, at 1:08 p.m. licensed practical nurse (LPN)-C stated the reason for giving an as needed medication, and the effectiveness of the

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21585	Continued From page 16 as needed medications were recorded on the back of the MAR. LPN-C stated would document the reason the as needed medication was given, and describe the behavior in the progress notes. LPN-C further stated R 21 would get distressed, and wants to go outside. LPN-C verified the MAR lacked the effectiveness of the as needed medications, and stated the effectiveness should be noted on the back of the MAR, or in the progress notes. On 6/7/18, at approximately 2:00 p.m. the director of nursing (DON) stated she would expect staff to document the effectiveness of as needed medications on the MAR or in a nurses note. The DON stated there were tabs in the MAR to pull out to remind them staff there needed to be a follow up on an as needed medication, and there was a process in place. The facility's Medication Administration policy dated 2/22/18, directed when an as needed medication was administered the effectiveness was to be documented. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could review and revise policies and procedures for ensuring the effectiveness of as needed antipsychotic medications were monitored. Staff could be educated as necessary. The director of nursing or designee could monitor on a regular basis to ensure continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21585		
21620	MN Rule 4658.1345 Labeling of Drugs	21620		7/17/18

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21620	Continued From page 17 Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medication labels provided the current directions for use for 2 of 6 residents (R29, R21) reviewed for medication administration. In addition, the facility failed to ensure controlled medications were properly disposed of following compromise of the secure seal of the unit dose packaging to prevent diversion for 2 of 15 residents (R2, R7) who received controlled medications. Findings include: R29's Admission Record printed 6/5/18, indicated R29's diagnoses included osteoarthritis and pain in the right shoulder. R29's signed Physician Orders dated 5/15/18, included orders for acetaminophen (pain reliever) 1000 milligrams (mg) by mouth three time daily and 500 mg by mouth twice daily as needed for pain with a maximum of 4000 mg/24 hours. R29's Medication Administration Record (MAR) for June 2018, indicated R29 was to receive acetaminophen 1000 mg three times daily and 500 mg twice daily as needed with a maximum of 4000 mg in 24 hours. On 6/4/18, at 4:36 p.m. registered nurse (RN)-A prepared R29's medication for administration. R29's medication card label for for acetaminophen directed R29 was to receive two 500 mg tablets (1000 mg) four times daily and	21620	corrected	

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one 500 mg tablet twice daily as needed for pain or fever. R29 received the medication as the physician ordered it.

On 6/4/18, at 6:00 p.m. RN-A verified the medication label for R29's acetaminophen was wrong, and if R29 had taken 1000 mg four times daily and 500 mg twice daily, R29 would have received more than 4000 mg of acetaminophen in 24 hours. RN-A put a "Directions changed refer to chart" sticker on the medication card label.

R21's Diagnosis Report printed 6/5/18, indicated R21's diagnoses included major depressive disorder, insomnia, and dementia with behavioral disturbance.

R21's signed Physician's Orders dated 5/31/18, included an order for Trazodone (antidepressant) 25 mg by mouth every p.m. for insomnia and anxiety.

R21's MAR for May and June 2018, indicated R21 was to receive Trazodone 25 mg by mouth every p.m. for insomnia and anxiety.

On 6/4/18, at 5:16 p.m. trained medication aide (TMA)-D prepared R21's medications for administration. R21's medication card label for Trazodone 50 mg tablets, directed R21 to receive 1/2 tablet (25 mg) by mouth daily at 5 p.m. and 1/2 tablet (25 mg) by mouth every bedtime as needed (prn) for insomnia and anxiety. TMA-D administered R21's Trazodone as the physician had ordered it.

On 6/4/18, at 6:14 p.m. the director of nursing (DON) verified R21 did not have an order to administer a prn dose of Trazodone, and was to have a scheduled dose of Trazodone 25 mg only,

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and stated the label was wrong. The DON stated R21 had not received a prn dose of Trazodone. The DON put a "Directions changed refer to chart" sticker on R21's medication card for Trazodone.

On 6/5/18, at 12:17 p.m. the DON stated the medication nurse should look at the labels with medication administration, and put a change in direction sticker on the card as necessary.

The facility policy and procedure for Medication Labels Changes dated 12/16, directed nursing to identify the medication container with an auxiliary label such as "Directions changed refer to chart" when the directions for use and/or dosage of the medication has changed, and the pharmacy should be notified of all new orders.

R2's Admission Record printed 6/5/18, indicated R2's diagnoses included osteoarthritis.

R2's signed Physician's Orders dated 5/31/18, included an order for oxycodone (narcotic pain medication) immediate release 5 mg one tablet by mouth every 6 hours as needed for severe pain.

On 6/5/18, at 9:46 a.m. during an audit of controlled narcotic medications, R2's oxycodone medication card had 41 tablets in the medication card, but tablet #41 had been opened in the back of the card and had a piece of tape over it, to hold the tablet in. There was also a piece of tape over #46, which had been used previously.

R7's Admission Record printed 6/5/18, indicated R7's diagnoses included chronic pain syndrome.

R7's Physician's Orders dated 5/31/18, included

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21620	Continued From page 20 an order for hydromorphone (narcotic pain medication) 1 mg twice daily as needed. On 6/5/18, at 9:46 a.m. during an audit of controlled narcotic medications, R7's hydromorphone medication card had 49 half tablets in the medication card, but tablet #50 had been opened in the back of the card, and had a piece of tape over it to hold the tablet in. On 6/5/18, at 9:46 a.m. licensed practical nurse (LPN)-C stated medications should not be taped back in the medication card, and should be destroyed with two staff by flushing in the sewer. On 6/5/18 at 9:57 a.m. licensed practical nurse LPN-B stated she would re-tape the medication into the card if there was just a small hold punched in the card, but if it were punched through, she would destroy the medication. On 6/5/18, at 12:17 p.m. the DON stated if medications are altered in anyway, they should be destroyed. The DON stated if the medication was punched out on the medication card, it would need to be wasted according to the facility policy. The facility policy and procedure for Controlled Medications Administration dated 12/16, lacked direction for management of controlled medications when the seal had been compromised and opened. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), pharmacist or their designee, could develop and implement policies/procedures and staff training related to medication labels and storage/ disposal of medications. The quality assessment and assurance committee could perform random	21620		

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21620	Continued From page 21 audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21620		