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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: TYBR
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 **03/17/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, HFE NEII 03/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 05/03/2016 (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
03/23/2016
(L33)

DETERMINATION APPROVAL

ID: TYBR
Facility ID: 00451

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

CCN: 24 5374

Lakeside Medical Center is a Special Focus Facility (SFF)

On March 17, 2016 and March 22, 2016, Departments of Health and Public Safety completed revisits to verify the facility achieved and maintained compliance with deficiencies issued pursuant to the February 4, 2016 standard survey. Based on the our visits, we have determined both health and life safety code deficiencies were corrected as of March 11, 2016. Refer to the CMS 2567b forms for both health and life safety code.

Effective March 11, 2016, the facility is certified for 46 skilled nursing facility beds.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245374

May 3, 2016

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

Dear Mr. Kallstrom:

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

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

Effective March 11, 2016 the above facility is certified for:

46 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 24, 2016

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

RE: Project Number S5374025

Dear Mr. Kallstrom:

On February 18, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 4, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), whereby corrections were required.

On March 17, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 22, 2016 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 February 4, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 11, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 4, 2016, effective March 11, 2016 and therefore remedies outlined in our letter to you dated February 18, 2016, will not be imposed.

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245374 (Y1)	A. Building B. Wing (Y2)	3/17/2016 (Y3)

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0314 Reg. # 483.25(c) LSC	Correction Completed 03/11/2016	ID Prefix F0356 Reg. # 483.30(e) LSC	Correction Completed 03/11/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) BF/mm	DATE 03/24/2016	SIGNATURE OF SURVEYOR 34987	DATE 03/17/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/4/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245374	A. Building 01 - MAIN BUILDING 01 B. Wing	3/22/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 03/11/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 03/11/2016	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 03/11/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) TL/mm	DATE 03/24/2016	SIGNATURE OF SURVEYOR 27200	DATE 03/22/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 2/4/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

March 24, 2016

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

Re: Reinspection Results - Project Number S5374025

Dear Mr. Kallstrom:

On March 17, 2016 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 February 4, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

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

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
00451		3/17/2016

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20302 Reg. # MN State Statute 144.6503 LSC	Correction Completed 03/11/2016	ID Prefix 20900 Reg. # MN Rule 4658.0525 Subp. 3 LSC	Correction Completed 03/11/2016	ID Prefix 21426 Reg. # MN St. Statute 144A.04 Subd. 3 LSC	Correction Completed 03/11/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) BF/mm	DATE 03/24/2016	SIGNATURE OF SURVEYOR 34987	DATE 03/17/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/4/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

EVENT ID: TYBR12

STATE FORM: REVISIT REPORT (11/06)

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: TYBR
Facility ID: 00451

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245374**

2. STATE VENDOR OR MEDICAID NO. (L2) **177550201**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/04/2016** (L34)

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

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Bruce Melchert, HFE NEII — 03/02/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 03/23/2016 (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 (L33)

DETERMINATION APPROVAL

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

CCN: 24 5374

Lakeside Medical Center is a Special Focus Facility (SFF)

On February 4, 2016 a standard survey was completed at this facility. The survey found the most serious deficiencies in the facility to be isolated deficiencies that constitute no actual harm with potential for more that minimal harm that is not immediate jeopardy (Level D). The facility has been given the opportunity to correct before remedies would be imposed. Post Certification Revisit (PCR) to follow. Refer to the CMS 2567 along with the plan of correction for both health and life safety code.

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 18, 2016

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

RE: Project Number S5374025

Dear Mr. Kallstrom:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On February 4, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Brenda.fischer@state.mn.us
Phone: (320) 223-7338   Fax: (320) 223-7348

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 March 15, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 May 4, 2016 (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 August 4, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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
Phone: (651) 430-3012   Fax: (651) 215-0525

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

Sincerely,

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

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

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 ______	02/04/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Lakeside Medical Center is a Special Focus Facility (SFF) and a certification survey was conducted on February 1-4, 2016. 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 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and documentation review the facility failed to ensure interventions were implemented to promote the healing of a pressure ulcer for 1 of 1 residents	F 314	It is the policy and procedure of Lakeside Medical Center to assess and provide interventions to promote healing and prevention of pressure ulcers. Pressure	3/11/16

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

Electronically Signed | | 02/25/2016

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

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F 314 Continued From page 1

(R29) identified with a current pressure ulcer.

Findings include:

R29's admission Minimum Data Set (MDS) dated 12/31/15, identified R29's had diagnoses which included diabetes mellitus, had an infected prosthetic knee joint, was cognitively intact, and required limited assistance from staff with transferring and extensive assistance with bed mobility. The MDS identified R29 was at risk for development of pressure ulcers and had a current, unstageable (meaning full-thickness tissue loss, in which actual depth of the ulcer is completely obscured by slough and/or in the wound bed) right heel pressure ulcer. The MDS also indicated there was a pressure reducing device for the R29's bed. R29's Care Area Assessment (CAA) dated 1/6/16, identified R29 had risk factors of immobility and functional limitation in range of motion.

R29's care plan, initiated on 12/11/15, directed staff to float heels off of bed to reduce pressure as allows. The care plan lacked documentation related to heel protectors R29 was to wear while in bed. A Kardex report dated 2/2/16, directed staff to float heels off of bed to reduce pressure as allows. A physician's progress note dated 12/22/15, indicated R29 was to continue with off-loading (reduction of pressure) of the heel and to wear heeled boot at all times in bed.

During observation on 2/2/16, at 3:08 p.m., R29 was lying in bed in her room, with both heels floated on a pillow but without any blue, soft-foam heel protector boots on either heel. There were two, blue, soft-foam heel protector boots set on a chair in R29's room. On 2/3/15, at 10:20 a.m.

F 314

ulcer policy has been reviewed and revised.

Resident #29 care plan has been reviewed and revised. Treatment administration record (TAR) and care plan were updated to include pressure reduction of heels via elevate heels and use of pressure reduction mattress. Discontinuation order of blue boots due to resident refusal was obtained. Negotiated risk agreement was completed between facility and resident as she refuses to wear the blue boots. All residents that refused recommended treatments by provider will have a negotiated risk agreement completed. All residents with pressure ulcers are monitored weekly by RN for effectiveness of current treatments and wound measurements. R29’s weekly wound measurements note that pressure ulcer is improving in status and getting smaller. Current orders for R29 wound care is open to air. Education was provided to resident on pressure ulcer prevention and healing. All residents that admit to the facility are currently and will continue to be educated on pressure ulcer prevention.

Education for nursing staff on wound care and pressure ulcer policy has been performed. Facility RN performs weekly wound assessment and updates provider on progress.

Audits have been performed on current residents with pressure ulcers to ensure compliance. Any new residents that admit

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F 314	Continued From page 2	F 314		

R29 was observed again in bed, with heels floated on a pillow, but was not wearing the blue, soft-foam heel protector boots while in bed.

On 2/3/16, at 12:47 p.m. R29 was observed in her room, with both heels floated on a pillow while lying in bed. R29 was not wearing the blue, soft-foam heel boots. In the presence of the surveyor, the assistant director of nursing (ADON) measured R29's pressure ulcer as 0.4 cm x 0.5 cm in size, with 100% eschar (dead tissue that is cast off from the surface of the skin).

During an interview on 2/4/16, at 8:28 a.m., R29 was in the dining area eating breakfast and stated "I have never heard" of the blue, soft-foam heel protectors when asked if R29 wore these boots.

An interview on 2/4/16, at 8:46 a.m. with nursing assistant (NA)-D stated R29 elevated her feet on a pillow while in bed, and was to wear heel protectors at bed time. NA-D also acknowledged R29 was not offered to wear the blue heel protectors while she was in bed.

The facility wound assessment flow sheet, undated, indicated R29's right heel pressure ulcer was present upon admission, and measured 1.1 centimeters (cm) in length x (by) 1.4 cm in width, and unstageable. Review of R29's skin/wound note of 12/9/15 indicated the "POC (plan of care) wound is left open to air and pressure relieving device." The skin/wound noted dated 12/27/15 indicated "has boot R29's wears in bed and floats heel". R29's subsequent wound assessment flowsheets indicated the following:

1/6/16, R29's right heel pressure ulcer

Provider's Plan of Correction (F 314):

with pressure ulcers will be audited for appropriate treatment plan. Results of audits will be reviewed at facility QAPI meeting.

Director of nursing is responsible for overall compliance.

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F 314	Continued From page 3 measured 1.1 cm x 1.3 cm; 1/13/16, R29's right heel pressure ulcer 1.1 cm x 0.7 cm; 1/20/16, R29's right heel pressure ulcer 0.8 cm x 0.5 cm; 1/27/16, R29's right heel pressure ulcer 0.6 cm x 0.6 cm; and on 2/3/16, R29's right heel pressure ulcer 0.4 cm x 0.5 cm. The wound documentation indicated R29's right heel pressure ulcer was assessed weekly, and the current POC (plan of care) "is OTA (open to air) and wear right heel protector when in bed." The weekly assessments for R29 also directed "to float heels if possible to reduce pressure; pressure relieving device of blue heel protectors." The documentation also indicated the R29's pressure ulcer was healing. An interview on 2/4/16, at 12:47 p.m. with registered nurse (RN)-B stated "staff should be offering" [R29] to wear the blue, soft foam heel protectors while in bed. RN-B verified that staff have not been offering R29 the blue, soft foam heel protectors. RN-B stated R29's care plan had been altered to reflect offer the blue soft foam heel protector boot to reduce pressure as allows on 2/3/16. A facility policy, Pressure Ulcers, dated 8/27/15, indicated resident are assessed and provided interventions to promote healing of pressure ulcers and to prevent development of pressure ulcers.	F 314		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356		3/11/16

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F 356	Continued From page 4 The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to consistently post the nurse staffing information for 2 of 4 days observed. This had the potential to affect all 33 residents who resided in the facility, along with interested family members and visitors.	F 356	It is a policy of Lakeside Medical Center to post the facility name, current date, the total number of actual hours worked of RN, LPN, CNAs. Nurse Staffing Information- Posted policy	

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F 356	Continued From page 5	F 356		

Findings include:

During initial tour on 2/1/16 at 1:15 p.m., the facility's nurse staffing information, posted near the A/B units' nursing station, was dated 1/31/2016 (the previous day's date). The "Lakeside Medical Center Nursing Staff Hours Report," dated 1/31/16, contained the appropriate staffing information as required, but not for the current day.

In an interview on 2/1/2016 at 1:31 p.m., the director of nursing (DON) said the facility information was "from yesterday," and also "the night shift usually changes that." Subsequently, the DON updated information into the computer for the current staffing schedule and census, and then posted the current information with today's date (2/1/16).

During observation on 2/4/2016 at 8:57 a.m. (the 3rd day of the survey), the facility staffing information was posted for 2/3/2016 (the previous day). The posting contained the appropriate information, but not the correct date.

In a subsequent interview on 2/4/2016 at 10:41 a.m., the DON realized the staff posting was not current, and also said "there should be changes made when there are call ins." The DON said that changes should be made to made to postings as they occur, and that postings were to be updated and posted every night for the upcoming day.

A facility policy, "Nurse Staffing Information, Posted," effective 7/30/2014, directed the following information would be posted to comply

was reviewed and updated by the IDT. The facility has posted the policy and provided education to staff. Inservice was provided to educate all nursing staff on 2/24/16.

The facility has created an audit to ensure that compliance has been obtained and maintained. The audit will be completed daily until compliance has been achieved for two consecutive weeks. After compliance, random audits will be performed to ensure compliance. Audit will be reviewed at facility QAPI meeting.

Director of nursing is responsible for overall compliance.

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F 356	Continued From page 6 with regulations: facility name; current date; total number and actual hours worked for registered and licensed practical nurses, and certified nursing assistants; and resident census. The policy further indicated the information "would be posted on a daily basis at the beginning of each day."	F 356		

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

F5374025

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245374	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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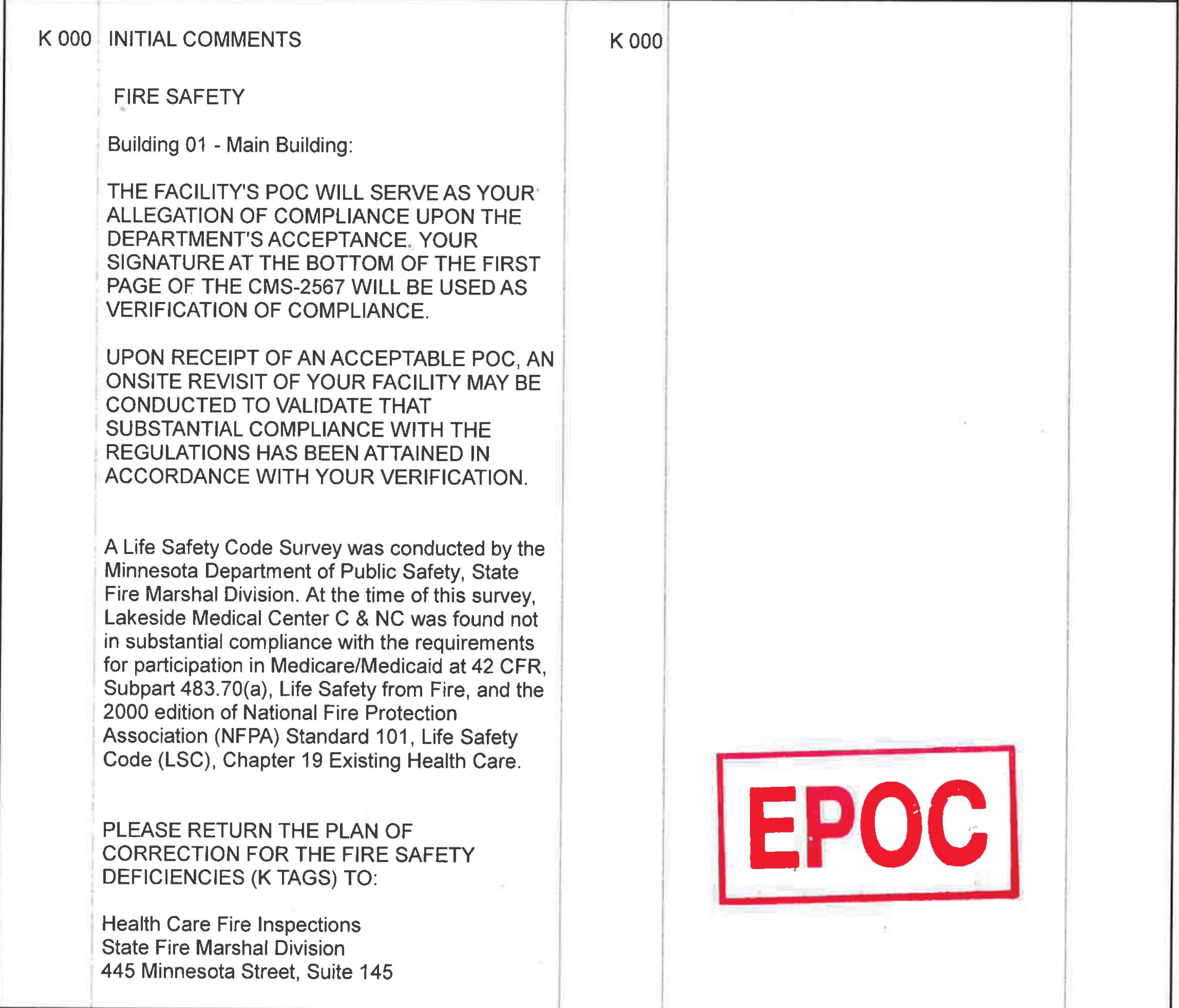

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K 000	INITIAL COMMENTS FIRE SAFETY Building 01 - Main Building: THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION 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 substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/25/2016

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 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us or 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 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	K 000		

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

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	245374	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**02/04/2016**

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K 000	Continued From page 2 and had a census of 32 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT met.	K 000		
K 056 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was found that the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect residents, visitors and staff of the facility. Findings include: On facility tour between 9:30 AM to 12:30 PM on 02/04/2016, observations revealed that the sprinkler head that is located in the storage room 165 was leaking a oily like substance. This deficient condition was verified by the	K 056	Escape Fire Protection will be out 3-1-16 to inspect and fix oily sprinkler. Jaime Burg EVS is responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	3/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 056	Continued From page 3 Administrator.	K 056		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect residents, staff and visitors. Findings include: On facility tour between 9:30 AM to 12:30 PM on 02/04/2016, a review of documentation and interview with the Administrator revealed that at the time of the inspection the facility could not provide any documentation for 3 of 4 quarterly fire sprinkler flow test having been completed. This deficient condition was verified by the Administrator.	K 062	When Escape Fire Protection is out on 3-1-16 to test sprinklers and fix oily sprinkler EVS will have him update facility on performing quarterly sprinkler flow tests. They will be conducted every quarter by maintenance personnel and documented on Quarterly Inspection Sheet that will be filed in the fire book after each quarter. Jaime Burg EVS will be responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	3/11/16
K 147 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1	K 147		3/11/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**02/04/2016**

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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K 147	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility had electrical appliances not in accordance with NFPA 70 (99), National Electrical Code. This deficient practice could negatively affect residents, staff and visitors. Findings include: On facility tour between 9:30 AM to 12:30 PM on 02/04/2016, it was observed that there is and extension cord running from a corridor outlet, through the ceiling tiles and was plugged into a power strip that was powering a computer Internet router that is also located above the ceiling tiles. This deficient condition was verified by the Administrator.	K 147	On 2-10-16 facilities electrician came to facility and wired an outlet for routers to be plugged in. No extension cord or power strip is being used at this time. Jaime Burg EVS is responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
February 18, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5374025

Dear Mr. Kallstrom:

The above facility was surveyed on February 1, 2016 through February 4, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order.

This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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 Brenda Fischer at (320) 223-7338 or email: brenda.fischer@state.mn.us**.

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

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

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

Sincerely,

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

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

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 ______	02/04/2016

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LAKESIDE MEDICAL CENTER	**129 EAST 6TH AVENUE PINE CITY, MN 55063**

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

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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 February 1-4, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		3/11/16

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2 302	Continued From page 3 Based on interview and document review, the facility failed to ensure residents and interested family were provided information regarding: the Alzheimer's dementia training staff received, who received training, how often, and a description of the training provided. This had the potential to affect all current and future residents of the facility and their families. Findings include: A review of employees' dementia care training on 2/3/2016 at 2:35 p.m. indicated the facility utilized a computer-based course "Dementia: A Refresher." The course's description identified the objectives to include: a description of dementia symptoms; how impaired brain function impacts daily life; a list of verbal and non-verbal communication methods; and problem solving methods. The facility provided evidence that all staff in the facility received this training, and that the training was required upon hire and annually thereafter. However, there was no indication this information was provided to current residents and family, in any form, either written or otherwise. In an interview on 2/3/2016 at 3:08 p.m. dietary manager (DM), who provided information regarding staff training, stated the facility "does not provide" information to consumers about the employee's dementia training, regarding the topics of the course, who is trained, and the frequency of the training. The DM said "We do not provide this." In an interview on 2/4/2016 at 8:12 a.m., the DM stated "a new document" was added "and will now be a part of the admission information."	2 302	Corrected. Completion date 03/11/2016.	

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2 302	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The administrator or designee could review its process to ensure: Alzheimer's training is timely completed by both facility and contracted nursing staff; and residents and interested others are made aware that dementia training is provided to staff, who received training, the frequency of training, and a description of the training topics. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and documentation review the facility failed to ensure interventions were implemented to promote the	2 900	Corrected. Completion date 03/11/16.	3/11/16

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2 900	Continued From page 5	2 900		

healing of a pressure ulcer for 1 of 1 residents (R29) identified with a current pressure ulcer.

Findings include:

R29's admission Minimum Data Set (MDS) dated 12/31/15, identified R29's had diagnoses which included diabetes mellitus, had an infected prosthetic knee joint, was cognitively intact, and required limited assistance from staff with transferring and extensive assistance with bed mobility. The MDS identified R29 was at risk for development of pressure ulcers and had a current, unstageable (meaning full-thickness tissue loss, in which actual depth of the ulcer is completely obscured by slough and/or in the wound bed) right heel pressure ulcer. The MDS also indicated there was a pressure reducing device for the R29's bed. R29's Care Area Assessment (CAA) dated 1/6/16, identified R29 had risk factors of immobility and functional limitation in range of motion.

R29's care plan, initiated on 12/11/15, directed staff to float heels off of bed to reduce pressure as allows. The care plan lacked documentation related to heel protectors R29 was to wear while in bed. A Kardex report dated 2/2/16, directed staff to float heels off of bed to reduce pressure as allows. A physician's progress note dated 12/22/15, indicated R29 was to continue with off-loading (reduction of pressure) of the heel and to wear heeled boot at all times in bed.

During observation on 2/2/16, at 3:08 p.m., R29 was lying in bed in her room, with both heels floated on a pillow but without any blue, soft-foam heel protector boots on either heel. There were two, blue, soft-foam heel protector boots set on a chair in R29's room. On 2/3/15, at 10:20 a.m.

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2 900	Continued From page 6	2 900		

R29 was observed again in bed, with heels floated on a pillow, but was not wearing the blue, soft-foam heel protector boots while in bed.

On 2/3/16, at 12:47 p.m. R29 was observed in her room, with both heels floated on a pillow while lying in bed. R29 was not wearing the blue, soft-foam heel boots. In the presence of the surveyor, the assistant director of nursing (ADON) measured R29's pressure ulcer as 0.4 cm x 0.5 cm in size, with 100% eschar (dead tissue that is cast off from the surface of the skin).

During an interview on 2/4/16, at 8:28 a.m., R29 was in the dining area eating breakfast and stated "I have never heard" of the blue, soft-foam heel protectors when asked if R29 wore these boots.

An interview on 2/4/16, at 8:46 a.m. with nursing assistant (NA)-D stated R29 elevated her feet on a pillow while in bed, and was to wear heel protectors at bed time. NA-D also acknowledged R29 was not offered to wear the blue heel protectors while she was in bed.

The facility wound assessment flow sheet, undated, indicated R29's right heel pressure ulcer was present upon admission, and measured 1.1 centimeters (cm) in length x (by) 1.4 cm in width, and unstageable. Review of R29's skin/wound note of 12/9/15 indicated the "POC (plan of care) wound is left open to air and pressure relieving device." The skin/wound noted dated 12/27/15 indicated "has boot R29's wears in bed and floats heel". R29's subsequent wound assessment flowsheets indicated the following:

1/6/16, R29's right heel pressure ulcer measured 1.1 cm x 1.3 cm;

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2 900	Continued From page 7	2 900		

1/13/16, R29's right heel pressure ulcer 1.1 cm x 0.7 cm;
1/20/16, R29's right heel pressure ulcer 0.8 cm x 0.5 cm;
1/27/16, R29's right heel pressure ulcer 0.6 cm x 0.6 cm; and on
2/3/16, R29's right heel pressure ulcer 0.4 cm x 0.5 cm.

The wound documentation indicated R29's right heel pressure ulcer was assessed weekly, and the current POC (plan of care) "is OTA (open to air) and wear right heel protector when in bed." The weekly assessments for R29 also directed "to float heels if possible to reduce pressure; pressure relieving device of blue heel protectors." The documentation also indicated the R29's pressure ulcer was healing.

An interview on 2/4/16, at 12:47 p.m. with registered nurse (RN)-B stated "staff should be offering" [R29] to wear the blue, soft foam heel protectors while in bed. RN-B verified that staff have not been offering R29 the blue, soft foam heel protectors. RN-B stated R29's care plan had been altered to reflect offer the blue soft foam heel protector boot to reduce pressure as allows on 2/3/16.

A facility policy, Pressure Ulcers, dated 8/27/15, indicated resident are assessed and provided interventions to promote healing of pressure ulcers and to prevent development of pressure ulcers.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers

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2 900	Continued From page 8 from developing, and to promote healing of pressure ulcers. The director of nursing or designee could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and documentation review the	21426	Corrected. Completion date 03/11/16.	3/11/16

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21426	Continued From page 9 facility failed to ensure the millimeters of induration for the tuberculin skin test (TST) were documented for 2 of 5 residents (R29 and R32); failed to document the TST outcomes for 1 of 5 residents (R40); and failed to complete a symptom screening for TST on 2 of 5 residents (R32 and R40). In addition, the facility failed to ensure 3 employees had complete tuberculosis screenings prior to working with residents; 2 employees failed to have TST's completed prior to working with residents; 1 employee had no reading of TST and 1 employee failed to have a completed the 2 step TST. This had the potential to affect all 33 residents. Findings include: R29 was admitted to the facility on 11/28/15 according to the admission record. A Mantoux PPD (purified protein derivative) Skin Testing for dated 11/28/15 indicated the first and second step TST had no millimeters (mm) of induration documented which is required per state rule. R32 was admitted to the facility on 10/2/15 according to the admission record. A Mantoux PPD Skin Testing form dated 10/2/15 indicated the first and second step TST had no mm of induration documented which is required per state rule. The form for the symptom screening of tuberculosis had not been completed for R32. R40's was admitted to the facility on 1/20/15 according to the admission record. The record review included a Laboratory Reports form undated that included TST had been completed 1/20/15 with no reading of negative or positive for the results of the first or second step of the TST which is required per state rule. R40's record review lack evidence of a symptom screening for	21426		

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LAKESIDE MEDICAL CENTER	**129 EAST 6TH AVENUE PINE CITY, MN 55063**

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21426	Continued From page 10 tuberculosis. A review of personnel files for a sample of new employee, identified nursing assistant (NA-A) was hired on 10/1/15. A review of NA-A personnel file lacked documented evidence of a tuberculosis symptom screen having been completed. NA-B was hired on 11/23/15. A tuberculosis screening was not evident in NA-B's personnel file and there was no evidence documented that NA-B had received the TST. Recreational therapist (RT) was hired on 8/11/15. A tuberculosis screening was not evident in RT's personnel file and there was no evidence documented that RT had received the TST. Housekeeper A was hired on 12/28/15. Although a first and second step TST had been administered, there was no evidence the reading mm of induration had been documented. NA-C was hired on 8/10/15. Although a first step TST had been completed. The personnel file lack documentation of the second step TST. During an interview on 2/4/16, at 8:39 a.m. with the director of nursing (DON) stated the standard here is to do the symptom screen for everyone. The DON verified residents and staff should have documented evidence the TST was completed at the facility or elsewhere. The DON stated mm of induration should be included in the documenting of the results of the TST. The facility policy Infection Control TB (tuberculosis) Control Plan Tuberculosis Screening-Residents undated directed staff to record skin test results in millimeters of induration	21426		

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 ______	02/04/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21426	Continued From page 11 rather than stating a result is positive or negative. The policy indicated the size of induration is recorded in the resident's medical record and immunization record. In addition, the residents should be screened annually and as necessary for active signs and symptoms of tuberculosis disease. The facility policy Infection Control TB Control Plan Tuberculosis Screening-Employees undated indicated it is the policy of this facility that all healthcare workers be tested for tuberculosis upon hire and screened annually, unless contraindicated. The policy indicated TST results will be documented in the employee's medical record, skin test results will be documented in millimeters of induration rather than stating result is positive or negative. Suggested Method for Correction: The administrator or designee could review the facility system in place to ensure newly admitted residents receive screening of TB symptoms and the TST as required by state rule. Revise the system as needed and educate staff on the system in place. Monitor and review the delivery of the TST and adjust the system as needed. Time Period for Correction: Twenty one (21) days	21426		