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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WGW3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00360

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245280**
2.STATE VENDOR OR MEDICAID NO.
(L2) **285042700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKEVIEW METHODIST HEALTH CARE CENTER**
(L4) **610 SUMMIT DRIVE**
(L5) **FAIRMONT, MN** (L6) **56031**

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 **06/04/2018** (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 **82** (L18)
13.Total Certified Beds **82** (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 __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	82			
(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 :
Holly Kranz, HFE NE II 08/09/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/09/2018 (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
06/01/1985
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245280
June 20, 2018

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

Dear Ms. Barnes:

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

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

Effective May 31, 2018 the above facility is certified for:

82 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 82 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
June 18, 2018

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

RE: Project Number S5280027

Dear Ms. Barnes:

On March 2, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by the Minnesota Department of Health, for the standard survey completed on February 16, 2018. The most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

On February 27, 2018, a survey team representing the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. The FMS 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).

On March 26, 2018, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 16, 2018. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of March 26, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 16, 2018.

On March 29, 2018, a survey team representing the Centers for Medicare and Medicaid Services (CMS) completed a Health Federal Monitoring Survey (FMS) of your facility. The FMS found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G).

The CMS Region V Office notified you of the following actions related to the imposed remedies in their letter of April 13, 2018:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 6, 2018. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of April 13, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 6, 2018.

On May 9, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the FMS survey completed on February 27, 2018 and the Health FMS survey completed on March 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 26, 2018. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our PCR completed on May 9, 2018. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of March 26, 2018:

- Discretionary Denial of Payment for New admissions effective May 6, 2018 will remain in effect. (42 CFR 488.417 (b))

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy:

- Civil money penalties. (42 CFR 488.430 through 488.444)

On June 4, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the PCR, completed on May 9, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 31, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 4, 2018.

This Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of April 13, 2018 :

- Civil money penalty. (42 CFR 488.430 through 488.444)

- Discretionary denial of payment for new Medicare and Medicaid admissions effective May 6, 2018 be discontinued effective May 31, 2018. (42 CFR 488.417 (b))

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

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,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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: WGW3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00360

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245280**
2.STATE VENDOR OR MEDICAID NO.
(L2) **285042700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKEVIEW METHODIST HEALTH CARE CENTER**
(L4) **610 SUMMIT DRIVE**
(L5) **FAIRMONT, MN** (L6) **56031**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/09/2018** (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 **82** (L18)
13.Total Certified Beds **82** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program
X 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
	82			
(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 :
Katy Hahn HFE NE II 05/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/09/2018 (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
06/01/1985
(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

May 23, 2018

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

RE: Project Number S5280027

Dear Ms. Barnes:

On March 2, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by the Minnesota Department of Health, for the standard survey completed on February 16, 2018. The most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

On March 26, 2018, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 16, 2018. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of March 26, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 16, 2018.

This was based on the deficiencies cited by a surveyor representing the office of the Centers for Medicare & Medicaid Services (CMS) for a Life Safety Code (LSC) Federal Monitoring Survey (FMS) February 27, 2018. The most serious deficiencies were found 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 April 13, 2018, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary Denial of Payment for New admissions effective May 6, 2018. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of April 13, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 6, 2018.

This was based on the deficiencies cited by a surveyor representing the office of the Centers for Medicare & Medicaid Services (CMS) for a Federal Monitoring Survey of your facility completed on March 29, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On May 9, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a LSC FMS survey completed on February 27, 2018 and a FMS Survey completed on March 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 26, 2018. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on May 9, 2018. The deficiencies not corrected are as follows:

E550 -- S/S: E -- **Residents Rights/Exercise of Rights 483.10(a)(1)(2)(b)(1)(2)**

F812-- S/S: F -- **Food Procurement, Store/Prepare/Serve-Sanitary 483.60(i)(1)(2)**

The most serious deficiencies in your facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of March 26, 2018:

- Discretionary Denial of Payment for New admissions effective May 6, 2018 will remain in effect. (42 CFR 488.417 (b))

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy:

- Civil money penalty for the deficiency cited at F550, F812. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, and appeal rights.

As the CMS Region V Office notified you in their letter of April 13, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is

prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 6, 2018.

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:

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

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. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

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 16, 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 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,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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
	245280	A. BUILDING _____ B. WING _____	R 05/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE FAIRMONT, MN 56031**

(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 An onsite post certification revisit was completed on 5/7, 5/8, and 5/9/18, to determine the status of Federal deficiencies issued during a Federal Monitoring Survey exited on 3/29/18. 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 550} SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	{F 550}		5/31/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/30/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	R 05/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE FAIRMONT, MN 56031**

(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 550}	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure residents received meals in a dignified manner when they served breakfast using paper products in 1 of 3 facility dining rooms (third floor). This deficient practice had the potential to affect 33 residents who ate in the third floor dining room. Findings include: During observation of the breakfast meal in the third floor dining room on 5/8/18 at 8:30 a.m., residents (R)5, R19, and R39 were served their hot cereal in paper bowls. During interview with R5 at the time of the observation, R5 stated hot cereal was frequently served out of paper bowls	{F 550}	On 5-8-18 The Care Coordinators on each floor cleared all cupboards in 2nd and 3rd floor dining rooms of all paper bowls, and instructed all nursing staff on duty 5-9-18 that if extra dishes are needed going forward they are to call the kitchen to bring up additional dishware. Remainder of nursing staff were instructed by Care Coordinators 5-10-18 and 5-11-18. The policy on Dishware written on 4-18-18 was amended on 5-24-18 to include the following statement: “Extra dishware shall be stored in in 2nd and 3rd floor dining room cupboards. No paper products will be stored on the floors	

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	245280	A. BUILDING _____ B. WING _____	R 05/09/2018

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{F 550}	Continued From page 2 for breakfast. R5 further stated her preference would be to have her cereal served in a glass/ceramic bowl. At 9:45 a.m. on 5/8/18, R9 and R62 were observed to be served hot cereal in paper bowls. Neither of these residents was able to clearly respond when questioned, due to cognitive impairment. During interview with nursing assistants (NA)-A, B and C on 5/8/18 at 9:57 a.m., each of the NAs stated they were responsible for serving residents a continental breakfast after 9:00 a.m. on the third floor. NA-A stated he had served the above residents their cereal in paper bowls for breakfast because the dining room's kitchen was out of glass/ceramic bowls. NA-A, NA-B and NA-C each acknowledged they had previously been made aware residents were to be served their breakfast using glassware instead of paper products. During interview with the facility's dietary director (DD) on 5/8/18 at 11:49 a.m., the DD stated the facility had enough glass dishware to serve all residents. The DD said if staff were to run out of dishware in the dining area, they should contact the kitchen to replenish the dining room cupboards. The DD further stated she had not been informed about staff running out of dishware and using paper bowls. The dietary director confirmed audits had not been completed to monitor for the use of glassware in the dining rooms.	{F 550}	for meal use." Starting 5-9-18 the Dietary Director discontinued ordering any meal service paper products. The only exception to this will be for Resident summer Holiday picnics. All staff will review these procedures at staff meeting on 5-31-18. Dietary Director responsible for implementation.	
{F 812} SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	{F 812}		5/31/18

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{F 812}	Continued From page 3 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure their dishmachine reached adequate final rinse temperatures to ensure heat sanitation of dishes. This deficient practice had the potential to affect all 69 residents who received meals from the facility's kitchen. Findings include: During observation on 5/8/18, at 11:00 a.m. in the second floor dining room, drinking glasses placed on tables in teh dining room appeared to have moisture droplets on the interior and exterior of the glasses. At that time, nursing assistant-D stated she had just transported the drinking glasses from the kitchen to the unit.	{F 812}	On 5-9-18 the Ecolab representative was called and arrived at Lakeview to check dishwasher. He adjusted the rinse cycle to a higher concentration of chemical, and the temperature registered at 184 degrees. Ecolab has been instructed to check dishwasher on a monthly basis by DD. The Infection Control Policy was changed on 5-10-18 to read “minimal final rinse temperature must read minimum of 180 degrees. If below this temperature maintenance must be called.” On 5-10-18 DD re-instructed dietary staff that temperatures must be recorded on temperature log. DD or DDA are auditing the log 5x week through June, 2018, and will then continue to audit weekly.	

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{F 812}	Continued From page 4 During interview with the dietary director (DD) on 5/8/18, at 2:00 p.m. the DD stated she thought there may be a problem with the chemical agent used in the rinse cycle of their dishmachine because glasses were not coming out as dry as they should. The DD stated dietary staff had just informed her drinking glasses weren't drying appropriately for the past couple of days. The DD stated she would contact the vendor to check on the dishwashing machine. At that time, the DD verified the facility's dishwasher utilized high temperature dish sanitization. During an observation and tour of the dishwashing room on 5/9/18, at 9:15 a.m. a load of dishes was currently in the dishmachine, and the indicator indicated the machine was in the final process of the rinse cycle. The temperature gauge reflected fluctuating temperatures between 134-154 degrees Fahrenheit (F) during the rinse cycle. Dietary assistant (DA)-A was questioned about the temperature, and confirmed he hadn't identified the low rinse temperature, he further stated he was unsure of the appropriate rinse temperature, but thought it should be at least 175 degrees F. DA-A said he would contact maintenance or the DD if the rinse temperature was below 175 degrees F. At the time, a posting was observed near the dishwasher indicating the minimal final rinse cycle temperature should be at 180 degrees F. During a follow up interview with the DD on 5/9/18 at 12:28 p.m., the DD stated she had not checked the final rinse temperature for the dishwasher nor the daily temperature logs. She said she thought there may have been a problem with the rinse agent and not the temperature. The DD also stated the final rinse temperature was supposed	{F 812}	All staff instructed on these procedures at all staff meeting on 5-31-18. Dietary Director responsible for implementation.	

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{F 812}	Continued From page 5 to reach 180 degrees F, and stated all dietary staff had received education for use of the machine. The DD stated she had not yet contacted the vendor for the dishwashing machine. During interview with the maintenance director on 5/9/18 at 1:45 p.m., the maintenance director stated preventive maintenance was conducted on the dishwasher monthly (including verification of water temperature) and that no concerns had been identified. The maintenance director provided maintenance logs which confirmed this information. The manufacturers's instructions for use of the dishwashing machine were reviewed. The instructions indicated to ensure sanitation, the final rinse temperature needed to reach 180 degrees F. Review of the facility's policy Food Handling, Storage and Preparation dated 4/28/18, indicated all dishes used for patient meal service will be washed following each meal in a commercial dish machine. The final rinse temperatures should be at least 170 degrees F. The contracted professional will check the function of the dish machine as well as the soap and final rinse titration monthly. Although the facility had a policy in place, the policy did not include the temperature recommended by the manufacturer for the final rinse cycle.	{F 812}		

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E 000	Initial Comments An Emergency Preparedness Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 3/29/18 following a Minnesota Department of Health (MDH) survey on 2/16/18. At this Comparative Federal Monitoring Survey, the Lakeview Methodist Health Care Center was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73 - Emergency Preparedness. The Lakeview Methodist Health Care Center has 82 dually certified beds. At the time of the survey, the census was 71. The requirement at 42 CFR, Subpart 483.73 was MET.	E 000		
F 000	INITIAL COMMENTS A health comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on March 29, 2018 following a Minnesota Department of Health (MDH) survey on February 16, 2018. Survey Dates: 3/26/2018 to 3/29/2018 Survey Census: 71 Medicare: 9 Medicaid: 37 Other: 25 Total: 71 Total Sample: 49	F 000		
F 550	Resident Rights/Exercise of Rights	F 550		4/26/18

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

Electronically Signed | 04/20/2018

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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F 550 SS=E	Continued From page 1 CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her	F 550		

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F 550	Continued From page 2 rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to treat residents with dignity and respect by utilizing paper products for meal service for breakfast meals in two of three facility dining rooms. This failure had the potential to affect residents who ate in the second and third floor dining rooms. Findings included: In an observation of the breakfast meal on 3/29/18 at approxiamtely 8:20am, the second and third floor dining rooms served the continental breakfast on paper dishware. In an interview with the Assistant Director of Activities on 3/29/18 at 8:25am when asked if there was a problem with the facility's dishwasher which made them used paper dishware, she stated, "We always use paper plates and styrofoam bowls for breakfast on second and third floor. It is the way it is for second and third floor for breakfast but on first floor, they use the regular [china wares]." During an interview on 3/29/18 at 1:51pm, the Dietary Manager was asked about the disposable dishware observed in the second and third floor dining rooms. She said the paper dishware was used for their continental breakfast on the second and third floor but there was not a reason for this. The facility did not provide a policy regarding dining room setup protocol.	F 550	Tablecloths and centerpieces have been ordered on 4/20/18 for all tables in dining rooms on second and third floors, which will be used at all meals. Dietary director is in charge of assuring compliance, has developed a policy for 2nd and 3rd floors in re: tablecloths. All staff educated on this procedure 4/20/18. Paper products will no longer be used for second and floor dining rooms, dishware will be used to serve all three meals. Dietary director in charge of assuring compliance, has developed a policy for the 2nd and 3rd floor dining rooms in re: dishware. All dining staff educated on this procedure on 4/20/18.	

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F 567 SS=E	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account,	F 567		4/26/18

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F 567	Continued From page 4 interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to keep resident funds in an interest-bearing account for 23 (R4, R9, R14, R16, R20, R22, R26, R30, R32, R35, R41, R43, R45, R46, R52, R53, R54, R55, R56, R57, R58, R71 and R73) of 33 Medicaid residents whose funds were in excess of $50.00; and six (R6, R13, R15, R50, R65 and R67) of 29 non-Medicaid residents whose funds were in excess of $100 in the sample of 49. Findings include: Review of "Trust - Current Account Balance" as of 3/28/18 revealed that 23 Medicaid residents (R4, R9, R14, R16, R20, R22, R26, R30, R32, R35, R41, R43, R45, R46, R52, R53, R54, R55, R56, R57, R58, R71 and R73) had personal funds in excess of $50.00 which ranged from $51.00 to $2,023.58. Further review of the same document revealed that six non-Medicaid residents (R6, R13, R15, R50, R65 and R67) had personal funds in excess of $100 which ranged from $112.80 to $314.00. In an interview with the facility's Financial Director on 3/29/18 at 4:26pm, she verified that the residents' personal funds were deposited in one checking account. She further stated, "It [the account] does not earn interest." In an interview with the Administrator on 3/20/18 at 5:15pm, she stated, "I am so used from my former job that I don't have to check into that [personal funds were deposited into	F 567	On 4/19/18, Finance Director contacted the bank with instructions to transfer the Resident trust fund from the present account into an interest-bearing account. The detailed individual accounting of Resident balance will continue as presently conducted. The accounts will now also be entered into a Point Click Care spreadsheet to determine interest per resident, and this interest amount will be added to each Resident's monthly trust fund statement if said resident has over $50 (MMA recipient) or over $100 (self pay). Finance Director has developed a new policy to reflect these changes 4/20/18. A letter explaining this change will be sent to all Residents with Trust Funds in their May, 2018 statement.	

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F 567	Continued From page 5 interest-bearing account]. We could easily fix that." Review of the facility's "Combined Federal and State Bill of Rights [given to the residents and resident representatives during admission]" with the last revision on 11/28/16 revealed under "Self-Determination" "...10...B. Deposit of funds...a. The facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)...b. Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50. In an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)..."	F 567		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		4/26/18

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F 580	Continued From page 6 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility	F 580	It is the policy of Lakeview Care Center to	

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F 580	Continued From page 7 failed to notify the physician or nurse practitioner of a change in skin condition for one (R8) resident; and, of a wound culture and sensitivity results timely for one (R38) resident in the sample of 49. Findings Include: 1. R8 was admitted to the facility on 1/19/17 with diagnoses including type II diabetes, diaper dermatitis (skin inflammation), congestive heart failure per the March 2018 "Physician Orders." Review of the medical record for R8 indicated the physician or nurse practitioner was not notified of the change in condition, specifically related to open areas located on the buttocks of R8, identified by staff as new on 3/28/18 at 11:30am. During an observation on 3/28/18 at 11:30am with Wound Care Nurse (WCN), R8's right and left buttock had an area of purple colored skin. The discolored area measured 13.0 centimeters (cm) x 13.0 cm, when measured by WCN, (the right and left buttock areas were measured together). There were three open areas noted on the right buttock that measured 0.5 cm x 1.0 cm, 0.8 cm x 1.0 cm, and 0.2 cm x 0.2 cm. WCN applied Zinc Oxide (a cream used to treat diaper rash, minor burns, severely chapped skin, or other minor skin irritations) to the area prior to replacing an incontinence brief. WCN documented that the open areas on R8's buttock was new. The areas were open but superficial and therefore, depth could not be measured. A wound assessment dated 3/28/18 "Weekly Wound Observation Tool" identified the condition as moisture associated dermatitis. Note included	F 580	inform the provider, resident and the resident's representative when there is a change in condition. Resident # R38 NP and resident representative have been informed of the wound and her end-stage disease process as well as family. Resident # R8 NP and resident representative have been informed of the wound and current treatment in place. Policy for change of condition, on all residents, was reviewed and staff were educated on policy and procedure for notification on change in condition on 4/16/2018. Changes in resident condition will be reviewed daily thru shift to shift report, use of communication board in Point Click Care, and with daily IDT stand up meetings. To ensure compliance will all residents the facility will audit daily x 1 week and 3x/week for 3 weeks with results reported for facility QAPI meeting. This will be done with IDT reviewing any changes and making sure provider are updated. Facility QAPI will review audit results for compliance. Director of Nursing is responsible for overall compliance. Completion date 4/26/2018.	

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the same measurements as above with no measurable depth of the open areas.

During an interview on 3/29/18 at 6:48pm the Director of Nursing (DON) said the Wound Nurse should document in the medical record when she notified the physician or nurse practitioner about open areas and she should notify them timely.

During an interview on 3/29/18 at 7pm Licensed Practical Nurse (LPN) 3 said nurses have a fax (facsimile) folder where they can put notifications they send out to physician. She looked for a notification for R8 and did not find one. LPN3 said nurses should document in a nurse's note or communication note when they notify the physician or nurse practitioner. She said if the nurses tell the physicians verbally they would make a note in the verbal order section of the chart. LPN3 said no one had communicated with her any changes in R8's condition or skin integrity.

During a phone interview on 3/29/18 at 7:21pm the Nurse Practitioner (NP) said, "I was not aware of the open areas on R8's buttocks." The NP also stated, "[I] was in the building at the time the wounds were discovered and should have been notified so I could assess them myself." She also said the staff did not contact her via phone. She said the facility staff have access to her during business hours and after hours for serious concerns like wounds. The NP said she would be contacted first and then the physician.

2. Record review of nursing progress notes for R38 dated 1/5/18 at 10:35pm indicated, "Culture came back on resident's back. It is positive for staphylococcus Auroras [sic]." There was no

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documentation found that the nurse practitioner or MD (medical doctor) were notified of the infection.

Record review of a form titled "Laboratory Services Report" with a date and time printed as 1/6/18 at 9:55am included a final report of "Staphylococcus Aureus 3+" with sensitivity results which informs the health care provider which antibiotic therapy is appropriate. In the progress notes, there is no documentation indicating a health care provider was notified to obtain orders for treatment to address the infection.

Record review of Nurse Practitioner's (NP) notes dated 1/9/18 indicated that R38 "is a [sic] 85 y.o. [year old] resident [name of facility] with Hypertension, CHF [congestive heart failure] Stroke with right sided weakness, history of MRSA [methicillin-resistant staphylococcus aureus, a bacteria with antibiotic resistance] in a wound to her neck..." In addition, the notes include, "She is was [sic] recently found to have a staph infection to her mid thoracic area on her back...Will start Keflex 500mg [milligrams] by mouth 3 times a day for 10 days. Nursing staff to monitor closely." However, the order was not written by the NP and the antibiotic was not started. This note was dated four days after the facility had obtained the culture results which showed infection in R38's thoracic pressure injury.

Nine days after the facility received a culture of staphylococcus aureus infection to R38's thoracic area, as evidenced by record review of the nursing progress notes dated 1/14/18 at 2:12pm, an order of "Keflex Capsule 500mg (Cephalexin)

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F 580	Continued From page 10 Give 1 capsule by mouth three times a day for Staph [staphylococcus] infection for 10days" was obtained. An interview was conducted with NP over the phone on 3/29/18 at 4:14pm regarding R38. When asked if she recalled being notified of R38's staphylococcus aureus infection, NP replied that she was "probably notified on 1/14/18." NP was asked to recall her notes when she visited R38 on 1/9/18. On NP's 1/9/18 notes, with the heading of "Reason for Visit," under "Wound Lower Back Open Initial" indicated, "Will start Keflex 500mg by mouth 3 times a day for 10 days." NP was asked as to why the Keflex was not started on that day. NP replied, "I might have not written it." Review of the undated "Physician Notification of Change" policy indicated "in the event of a significant change in the resident's physical, mental or psychosocial status in either life threatening conditions or clinical compilations the facility RN or LPN will inform the resident, consult with the resident's physician or on-call physician, and notify the resident's legal representative or designated family member."	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's	F 656		4/26/18

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F 656	Continued From page 11 medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop individualized interventions to address care problems related to use of indwelling Foley catheter for one (R43) of one	F 656	It is the policy and procedure of Lakeview Care Center to develop an interdisciplinary, comprehensive individualized care plan. Per policy, all the	

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F 656	Continued From page 12 resident reviewed for use of indwelling Foley catheter in the sample of 49. Findings include: R43 was admitted to the facility on 6/29/16 with diagnoses which included the following: benign prostatic hyperplasia with lower urinary tract symptoms, calculus of kidney and retention of urine. Review of R43's Care Plans revealed that there was a care plan for R43's use of indwelling Foley catheter. Review of the same care plan revealed that the only intervention was "Position catheter bag and tubing below the level of the bladder and away from entrance room door." Review of the Medication Review Report for the month of March revealed the following orders: "...Change Foley Catheter Q [every] month - 16 French, inflate balloon to 10cc every evening shift starting on the 12th and ending on the 12th every month...Irrigate indwelling catheter with sterile normal saline for obstruction..." Review of R43's current care plan for the use of indwelling Foley catheter and medication review report revealed no interventions or orders related to the care of indwelling Foley catheter care and how often the Foley care should be done nor was there any instruction to monitor for signs and symptoms of infection or complications. Review of the Kardex (a medical information system used by nursing staff as a way to communicate important information on their patients) for the second floor south wing revealed under general info (information) that R43 had an	F 656	comprehensive, person centered care plan is developed and completed within the required comprehensive assessment (MDS). Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' condition change. Resident #R43 Care plan has been reviewed and revised to address history of urinary tract infections. R43 and all residents with Foley catheters care plans were reviewed and updated. Orders received on all residents with Foley catheters to provide Foley catheter care daily, all triggered care plans were updated as per policy. Care plans are developed upon admission and are reviewed and revised at a minimum quarterly. Care plan will address resident history of urinary tract infections along with interventions for identification and prevention. All nurses involved in the development of the care plan have been trained 4/17/2018 in the development of a resident centered care plan for all residents with a current and a history of a urinary tract infection. An audit for all residents with a diagnosis of a historical urinary tract infection will be reviewed for appropriate problem, goal and intervention to identify and prevent urinary tract infections. An audit for current residents with a newly diagnosed UTI will be performed 3x/week for 2 weeks with results reported to facility QAPI meeting. Facility QAPI will review audit results for compliance. Director of Nursing is responsible for overall compliance.	

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F 656	Continued From page 13 indwelling Foley catheter but there was no instruction related to its care. In an interview with the Director of Nursing (DON) on 3/29/18 at approximately 7:19pm, when asked about the lack of order for R43's indwelling Foley catheter care, the DON stated "It is just automatic for residents with catheter to have Foley care in their [nursing aides'] task." Review of the facility's undated "Care Plans, Comprehensive Person-Centered" policy revealed "...8. The comprehensive, person-centered care plan will:...b. Describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being...l. Identify the professional services that are responsible for each element of care...o. Reflect currently recognized standards of practice for problem areas and conditions..." According to Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual published on October 2016 under Section 4.6 "When Is the RAI Not Enough?" on page 4-7, "...facilities are responsible for assessing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI (42 CFR 483.20(b)), including monitoring each resident's condition and responding with appropriate interventions." The Manual also stated under "Limitations of the RAI-related instruments...The RAI provides tools related to assessment including substantial detail for completing the MDS, how CATs [Care Area Triggers] are triggered, and a framework for the CAA [Care Area Assessment] process. However, the process of completing the MDS and related	F 656	Completion date 4/26/2018.	

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F 656	Continued From page 14 portions of the RAI does not constitute the entire assessment that may be needed to address issues and manage the care of individual residents. Neither the MDS nor the remainder of the RAI includes all of the steps, relevant factors, analyses, or conclusions needed for clinical problem solving and decision making for the care of nursing home residents..."	F 656		
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 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.	F 657		4/26/18

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F 657	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to revise care plans to reflect actual care needs for three (R8, R9 and R38) of 18 residents reviewed for care plans in the sample of 49. Findings include: 1. Review of the "Physicians Orders" dated March 2018, R8 was admitted to the facility on 1/19/17 with diagnoses including type II diabetes, diaper dermatitis (skin inflammation), and congestive heart failure. Review of the quarterly "Minimum Data Set" (MDS), a comprehensive assessment tool completed by the facility staff, dated 12/20/17, indicated R8 needed extensive, two persons assist with transfers and positioning. The resident was documented as frequently incontinent of bowel and bladder. Review of the MDS for evidence of pressure ulcer evidenced no pressure ulcers but was at risk to develop. R8 also utilized a wheelchair for mobility. R8 was cognitively intact with a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15. Review of the care plan dated 5/01/17 indicated R8 required assist by one staff to turn and reposition. R8 was care planned to have incontinent care every two hours and as needed. The care plan did not indicate the resident had open wounds. It also did not indicate any new interventions put in place to prevent further skin breakdown. According to the facility's "Braden Scale" (a scale	F 657	It is the policy and procedure of Lakeview Care Center to develop, and revise, as needed, an interdisciplinary, comprehensive individualized care plan. All care plans will be reviewed quarterly and as needed. Resident #R8 Care plan has been reviewed and revised to address moisture associated skin damage. Resident care tasks updated to ask R8 and encourage him to reposition and check for incontinence Resident #R9 Care plan has been reviewed and revised to address incontinence and resident refusals. Resident #R38 Care plan has been reviewed and revised to address pressure injury. Care plans are developed upon admission and revised with a resident change in condition and at a minimum quarterly. Care plan will address any changes identified thru shift to shift report and with daily interdisciplinary meetings in coordination with the primary NP/MD. All nurses involved in the development of the care plan have been trained 4/17/2018 on development of a resident centered care plan for all residents with incontinence and pressure injuries. An audit for accuracy of resident care plan will be performed quarterly with resident assessments, interviews and completion of the RAI process. Care plans will be reviewed for appropriate problems, goal and interventions. A care plan audit will be performed for current residents who have	

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F 657	Continued From page 16 used for predicting pressure sore risk) R8 was an "15" which indicated R8 was "at risk" for developing pressure ulcers. During an observation on 3/28/18 at 11:30am with Wound Care Nurse (WCN), R8's right and left buttock had an area of purple colored skin. The discolored area measured 13.0 centimeters (cm) x 13.0 cm, when measured by WCN, (the right and left buttock areas were measured together). There were three open areas noted on the right buttock that measured 0.5 cm x 1.0 cm; 0.8 cm x 1.0 cm; and 0.2 cm x 0.2 cm. WCN applied Zinc Oxide (a cream used to treat diaper rash, minor burns, severely chapped skin, or other minor skin irritations) to the area prior to replacing a disposable brief for R8. WCN documented that the open areas on R8's buttock were new. During an interview on 3/29/18 at 2:34pm the Director of Nursing (DON) said if R8 had open areas on his buttock he would expect the nurses to update the care plan when the wound was discovered and communicate new interventions with the staff. During an interview on 3/29/18 at 4:53pm Licensed Practical Nurse (LPN) 1 said since 3/28/18 no one had communicated with him regarding R8's wounds, offloading or repositioning. During a phone interview on 3/29/18 at 7:21pm the Nurse Practitioner (NP) said she was not aware of the open areas on R8's buttocks. She said she would expect the facility staff to update the care plan and put new interventions in place to specifically address the compromised skin integrity once the wounds were discovered. She	F 657	had a change in incontinence and/or a pressure injury with results reported to facility QAPI committee. Facility QAPI will review audit results for compliance. Director of Nursing is responsible for overall compliance. completion date 4/26/2018.	

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F 657	Continued From page 17 also expected nurses to communicate with each other and other staff regarding said interventions. 2. Observation of NA3 (nursing aide) on 3/29/18 at 10:31am revealed that NA3 entered R9's room and offered to change clothes and wash up but the resident refused. In an interview with NA4 on 3/29/18 at 11:26am, NA4 stated, "I was told she has been refusing cares so I am going to try." Observation of NA4 revealed that she offered to do cares but R9 refused. In an interview with LPN4 (licensed practical nurse) on 3/29/18 at approximately 12:26pm, LPN4 stated, "I offered to toilet and check her [R9's] incontinence brief but she refused." She further stated, I expect them [nursing aides] to at least offer to check because I know she usually refuse." In an interview with the DON (director of nursing) on 3/29/18 at approximately 3:10pm when told about the above findings and observation of R9, he stated, "[R9] is extremely not compliant." When the DON was asked if the care plan should have been revised to reflect R9's refusal to toileting and incontinence care, he stated, "If it was indicated in the care plan that she was refusing ADLs [activities of daily living] then it covers the incontinence care." Review of R9's current care plan related to "Bladder Incontinence" under interventions revealed, " ...INCONTINENT: Check every 2 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes..."	F 657		

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F 657	Continued From page 18 Review of R9's current "ADL Self-Care Performance Deficit" care plan revealed interventions which included the following: " ...TOILET USE: The resident requires assist of 1 staff for toileting needs...TOILETING SCHEDULE: Resident has bowel and bladder incontinence with control present. Has hx [history] of removing clothing and voiding in bed and then redressing. Staff to cue resident to use toilet with AM [morning] and HS [hours of sleep] cares, within 1 hour before/after meals and activities, and PRN [as needed]." Further review of R9's "ADL Self-Care Performance Deficit" care plan revealed that R9 had a history of refusing to change clothing; often refused to get out of bed in the morning; and, frequently refused bathing. There was no indication in the care plan that R9 refused toileting or incontinence care. Review of R9's electronic health record revealed no documentation that these refusals were documented and education regarding the risks and benefits of refusing toileting and incontinence care was provided to the resident. 3. Record review of R38's nursing progress notes dated 12/18/17 at 6:43pm which is the first entry of skin breakdown to the thoracic area revealed, "Res [resident] has a new pressure area on her upper spine. Area all together measures 3cm x 2.5cm. Open area 1cm x 1cm. Notified [name of resident's nurse practitioner] through fax [facsimile]." Record review of R38's Care Plan under the heading of "Focus" indicated, "The resident has	F 657		

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potential for impairment to skin integrity r/t [related to] fragile skin and impaired mobility. Resident has history of an open blister on right heel, resolved. Open area to center back, spine. Kerra Pro, [a pressure reducing pad] applied for protection. Open area to coccyx R/T [related to] friction as resident slides on bed sheets. Treatment in place. Date Initiated: 10/11/2016. Revision on: 01/15/2018." In the R38's Care Plan, under the heading of "Interventions/Tasks" which serves as a means of communication to the nursing staff that a specific and tailored treatment is being implemented, there were no interventions listed that addresses R38's thoracic wound from 12/18/17 when R38's thoracic wound was first detected to 3/29/18.

An interview conducted with the Administrator, Director of Nursing (DON), and Wound Care Nurse on 3/29/18 at 4:20pm. The Care Plan for R38 was shown to the DON, and the DON was asked if he could identify any interventions in the Care Plan regarding R38's thoracic wound which was first detected on 12/18/17. The DON replied, "Looks like we haven't been monitoring..."

Review of the facility's undated Policy titled "Care Plans, Comprehensive Person-Centered" indicated under Policy Interpretation and Implementation, "...8. The comprehensive, person-centered care plan will:...c. Describe services that would otherwise be provided for the above, but are not provided due to the resident exercising his or her rights, including the right to refuse treatment...g. Incorporate identified problem areas...13. Assessments of residents are ongoing and care plans are revised as information about the residents and the resident's conditions change. 14. The Interdisciplinary Team

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F 657	Continued From page 20 must review and update the care plan:...b. When the desired outcome is not met..." According to Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual Version 1.14, October 2016, Chapter 4 page 8 indicated, "...The care plan must be reviewed and revised periodically, and the services provided or arranged must be consistent with each resident's written plan of care...The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving..."	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure assistance with activities of daily living (ADL), including toileting and/or incontinence care were provided for two (R8, R9) of three residents who were assessed to require staff assistance for activities of daily living in the sample of 49. Findings include: 1. Observation of R9 on 3/29/18 from 8:15am until 12 noon revealed that R9 was not seen toileted nor checked for incontinence. Observation of NA3 (nursing aide) on 3/29/18 at 10:31am revealed that NA3 entered R9's room	F 677	R9 staff to encourage incontinence care every two hours and to document refusals in the chart. R8 – Staff to continue to do 1 hour Pad checks during the day, staff to ask R8 to allow to check and change him. On 4.16.18. R8 to use overnight brief for incontinence, care plan updated. The nurse aide sheets were updated. Care plan indicates to use 1-2 staff for bed mobility. Changed repositioning task on 4.16.18 stating ask R8 if you can reposition him. Staff to provided education as needed to the resident, staff to document refusals. An audit for all residents with a diagnosis	4/26/18

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F 677	Continued From page 21 and offered to change clothes and wash up R9 but the resident refused. NA3 did not check R9 for incontinence. Observation of NA1 on 3/29/18 at 11am revealed that NA1 entered R9's room to offer pudding, water or ice chips which the resident refused. NA1 did not check R9 for incontinence. In an interview with NA4 on 3/29/18 at 11:26am, NA4 stated, "I was told she has been refusing cares so I am going to try." Observation of NA4 revealed that she offered to do cares but R9 refused. NA4 did not check R9 for incontinence. In an interview with NA3 on 3/29/18 at 12:16pm, NA3 verified that she did not check R9 for incontinence. NA3 further stated, "I did not check her incontinence brief. I was not sure if somebody was in there to do incontinence care or toileting. My main purpose was to give her morning cares if she would allow." In an interview with LPN4 (licensed practical nurse) on 3/29/18 at approximately 12:26pm, LPN4 stated, "I offered to toilet and check her [R9's] incontinence brief but she refused." When asked if the aides were expected to check R9 for incontinence, LPN4 stated, "I expect them to at least offer to check because I know she usually refuse." In an interview with NA1 on 3/29/18 at 12:28pm when asked if she checked R9 for incontinence when she went to R9's room, NA1 stated, "That [check R9 for incontinence] I did not [do] because I know the other aide was in there before I was." Review of R9's Medication Review Report for the	F 677	of incontinence will be reviewed for appropriate problem, goal and intervention to identify incontinence and refusals. An audit for current residents with a diagnosis of incontinence will be performed 3x/week for 2 weeks with results reported to facility QAPI meeting. An audit for all current residents, who require assistance with turning and repositioning, will be performed 3x/week for 2 weeks. Results reported to facility QAPI meeting. Facility QAPI will review audit results for compliance. Director of Nursing is responsible for overall compliance. Completion date 4/26/2018.	

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month of March 2018 revealed an admission date of 12/6/10 with diagnoses which included the following: anxiety disorder and major depressive disorder.

Review of the R9's Quarterly MDS (Minimum Data Set) 3.0 Assessment, dated 12/20/17 indicated the resident had a severe cognitive impairment. The MDS also indicated the resident required extensive assistance of two or more persons with toilet use. Review of the same MDS revealed that R9 had dementia.

Review of R9's current care plan related to "Bladder Incontinence" under interventions revealed, "...INCONTINENT: Check every 2 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes..."

Review of R9's current "ADL Self-Care Performance Deficit" care plan revealed interventions which included the following: "...TOILET USE: The resident requires assist of 1 staff for toileting needs...TOILETING SCHEDULE: Resident has bowel and bladder incontinence with control present. Has hx [history] of removing clothing and voiding in bed and then redressing. Staff to cue resident to use toilet with AM [morning] and HS [hours of sleep] cares, within 1 hour before/after meals and activities, and PRN [as needed]."

On 3/29/18 at 3:10pm, in an interview with the Director of Nursing (DON) the surveyor told the DON about these findings and observations. When asked of his expectations of his nursing staff, the DON stated, "Check on her [R9] and see if she is incontinent." The DON further stated,

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"[There are] multiple ways, ask her, check the pad, check for odor, check the indicator first." He also stated, "We need to take the opportunities to check if she's incontinent while they are in there. If it were me, I'll check the pad or offer to check it. We missed the opportunities."

2. Review of the "Physicians Orders" dated March 2018, R8 was admitted to the facility on 1/19/17 with diagnoses including type II diabetes, diaper dermatitis, congestive heart failure.

Review of the quarterly "Minimum Data Set" (MDS), a comprehensive assessment tool completed by the facility staff, dated 12/20/17 indicated R8 needed extensive, two persons assist with transfers, and positioning. The resident was identified as frequently incontinent of bowel and bladder and required two persons assist for incontinence care. R8 utilized a wheelchair for mobility. R8 was cognitively intact with a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15.

Review of the care plan dated 5/01/17 indicated R8 required assist by one staff to turn and reposition. R8 was care planned to have incontinent care every two hours and as needed.

During an interview on 3/29/18 at 12:15pm R8 said he was brought back to his room from eating lunch. He said he had not been to the bathroom since this morning or repositioned by staff. The resident was asked if he could reposition himself. The resident attempted to reposition himself but was unable to reposition when up in his wheel chair. The resident has a deficit of one upper extremity.

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F 677	Continued From page 24 During an interview on 3/29/18 at 12:41pm the Wound Care Nurse and the Assistant Director of Nursing said R8 should have been repositioned during the three and a half hours he was in his wheelchair. They also said he should be checked for incontinence every two hours and as needed. Review of the facility's undated "Activities of Daily Living (ADL) (Daily Life Functions)" policy and procedure revealed under purpose, "1. To assist resident in achieving maximum functional ability and self-esteem; 2. To provide assistance to residents as necessary...6. To improve quality of life." Review of the facility's undated "Urinary Continence and Incontinence - Assessment and Management" policy revealed under Policy Interpretation and Implementation, "...18. As indicated, and if the individual remains incontinent despite treating transient causes of incontinence, the staff will initiate a toileting plan ...a. As appropriate, based on assessing the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to manage incontinence..."	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F 684		4/26/18

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F 684	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide care and services necessary for one resident (R8) with open skin lesions of 49 sampled residents. The facility staff failed to provide re-positioning or offloading for a resident with open skin lesions on the buttocks. Findings Include: Review of the "Physician's Orders" for R8 dated March 2018 revealed he was admitted to the facility on 1/19/17 with diagnoses including type II diabetes, diaper dermatitis (skin inflammation), and congestive heart failure. Review of the quarterly "Minimum Data Set" (MDS), a comprehensive assessment tool completed by the facility staff, dated 12/20/17 indicated R8 needed extensive, two persons assist with transfers and positioning. R8 also utilized a wheelchair for mobility. R8 was cognitively intact with a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15. The MDS documented R8 had MASD (moisture associated dermatitis) and was at risk for pressure sores. The MDS also indicated he was on a turn/repositioning schedule and incontinent of bowel and bladder which required two persons assist with toileting. Review of the care plan dated 5/01/17 indicated R8 required assist by one staff to turn and reposition. The care plan indicated staff were to provide incontinence care every two hours and as needed.	F 684	R8 – Staff to continue to do 2 hour repositioning, staff to ask R8 to allow to check and change him4.16.18. R8 requests that he not be awakened during HS hours for repositioning. Risk benefit signed by resident to not be awakened, due to increased chance of skin breakdown. Nurse aide sheets updated to promote standing with EZ stand to offload during cares with a goal of 15 minutes. Care plan indicates to use 1-2 staff for bed mobility. OT order obtained on 4.16.18 to check wheelchair positioning and fitting. Changed repositioning task on 4.16.18 stating ask R8 if you can reposition him. Provided education as needed, staff to document refusals. An audit for all current residents with and without skin breakdown and immobility will be performed 3x/week for 2 weeks with results reported to facility QAPI meeting. Going forward licensed nursing staff will complete weekly skin audits on all residents. To sustain compliance floor nurses, resident care coordinator and DON will monitor repositioning and complete audits for all residents. Completion date 4/26/2018.	

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According to R8's undated "Braden Scale" (a scale used for predicting pressure sore risk) R8 was a "15" which indicated R8 was "at risk" for developing pressure ulcers.

Review of a "Wound Care Skin Integrity Evaluation" dated 3/14/18 indicated R8's wound was assessed by the DME Representative, Wound 1, Buttock Right partial thickness, MASD 12.00 cm x 0.9 cm depth 0.2 cm.

During an observation on 3/28/18 at 11:30am with Wound Care Nurse (WCN), R8's right and left buttock had an area of purple colored skin. The discolored area measured 13.0 centimeters (cm) x 13.0 cm, when measured by the WCN, (the right and left buttock areas were measured together). There were three open areas noted on the right buttock that measured 0.5 cm x 1.0 cm; 0.8 cm x 1.0 cm; and 0.2 cm x 0.2 cm. WCN applied Zinc Oxide (a cream used to treat diaper rash, minor burns, severely chapped skin, or other minor skin irritations) to the areas prior to replacing the disposable brief. WCN documented that the open areas on R8's buttocks were new. The areas were open but was unable to provide a depth measurement.

Review of the wound assessment per the "Weekly Wound Observation Tool" dated 03/28/18 revealed the same measurements as noted above with no measurable depth of the open areas.

During an interview on 3/29/18 at 12:15pm R8 said he was brought back to his room from eating lunch. He said he had not been to the bathroom since this morning or repositioned by staff. The resident was asked if he could reposition himself.

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The resident attempted to reposition himself but was unable to reposition when up in his wheel chair.

During an observation of the resident's skin condition, after being up in a chair for 3.75 hours, on 3/29/18 at 12:45pm, the reddish, purple area on R8's right buttock measured 11.5 cm by 11.0 cm and on the left buttock 10 cm by 4.2 cm. There were three open areas on the right buttock that measured 0.4 cm x 1 cm, 0.3 x 0.8 cm, 0.4 cm by 0.5 cm. He was not incontinent of urine. The WCN told the nurse's aide to leave R8 in bed, on his side for a period of 20 minutes so the pressure would be offloaded from the open areas.

During an interview on 3/29/18 at 2:34pm the Director of Nursing (DON) said if R8 had open areas on his buttock he would expect the staff to assist him with repositioning to offload the pressure.

During an interview on 3/28/18 4:23pm WCN said the DME Representative had assessed the resident's wounds periodically up until 3/22/18 when he was sent out to the wound clinic.

During an interview on 3/29/18 at 4:53pm Licensed Practical Nurse (LPN) 1 said since 3/28/18 no one had communicated with him regarding R8's wounds, offloading or repositioning.

During a telephone interview on 3/29/18 at 7:21pm, the Nurse Practitioner (NP) said, "I was not aware of the open areas on R8's buttocks." The NP also said, "[I] was in the building at the time the wounds were discovered and should

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F 684	Continued From page 28 have been notified so I could assess them myself." She further stated, "Dermatitis would occur in the resident's perineal area but if he had open areas on his buttocks I would associate those with pressure." The NP also said, "[I] would expect the resident not to sit directly on his "bottom" for four hours without offloading or repositioning to prevent further skin breakdown." She further stated, "[I] expected the nurses to communicate with the aides and other staff regarding new wounds and the interventions that should have taken place."	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to prevent the development of an avoidable, unstageable pressure injury (pressure ulcer) which deteriorated and became infected resulting in harm for 1 (R38) of 4 residents reviewed for pressure injuries in a sample of 49.	F 686	R38=Verbal order to see Wound therapy at Mayo clinic Health Systems – Fairmont on 3/29/2018. R38 was seen by wound therapy at Mayo Clinic Health Systems of Fairmont on 4/4/2018 @ 1:00pm. Received order for Juven (Supplement) to promote healing on 3/29/18. Resident is	4/26/18

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F 686	Continued From page 29 Findings include: Record Review of document titled "Progress Notes" for R38, dated 3/28/18 revealed that R38's diagnosis included but were not limited to: history of methicillin resistant staphylococcus aureus infection (MRSA), personal history of transient ischemic attack, cerebral infarction (stroke) and hemiplegia (paralysis on one side of the body). Record Review of the most recent "Braden Scale for Predicting Pressure Sore Risk" for R38, dated 11/5/17 indicated a score of 18 which rated R38 at risk for developing a pressure injury. Record Review of R38's nursing progress notes revealed a note for 12/18/17 at 6:43pm, "Res [resident] has a new pressure area on her upper spine. Area all together measures 3cm [centimeter] x 2.5cm. Open area 1cm x 1cm. Notified [name of resident's nurse practitioner] through fax..." This was the first documentation by the facility of R'38's skin breakdown. Record Review of R38's nursing progress notes dated 12/19/18 revealed the following entry signed by the Director of Nursing (DON), "Follow up with Evening LPN [licensed practical nurse]. She states that [name of resident] has stopped wearing her bra because it was rubbing on area. This may be the source of the sore. Will continue to monitor." During an interview with LPN6, designated as Resident Care Coordinator, on 3/28/18 at 3:40pm, LPN6 was asked if R38 needed assistance in removing her bra at night before bedtime. Because of R38's right sided weakness	F 686	on comfort cares and has been since 5/22/2017. Was seen by nurse practitioner on 4/17/2018. R 38's wound originally started from her bra. R38 has refused an air mattress and is now utilizing a pressure reducing mattress. R38 continues to have a pressure-reducing cushion on her back and one that she sits on. R38 continues to have a memory foam overlay on bed, on top of the pressure-reducing mattress. Staff encourage her to sleep on her side. Resident's medical chart was reviewed by facility's medical director on 4/18/2018. Per Medical Director note on 4/18/2018, "Despite the implementation of the usual, standard skin care procedures and protective strategies, and as a direct result of her chronic medical conditions, Mrs. Harder developed the skin lesions noted above." "In summary, despite standard interventions to assist in both the healing of and prevention of further progression of Mrs. Harder's skin lesions, their development, presence, and delayed resolution are complicated, if not a direct result of, her multiple extensive medical issues" per Medical Director. Residents without pressure ulcers will continue to receive care, consistent with professional standards of practice to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they are unavoidable. All residents with pressure ulcers will continue to receive necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent	

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F 686	Continued From page 30 secondary to a stroke, LPN6 replied that R38 required assistance. LPN6 was then asked as to why R38's thoracic pressure injury was first discovered at a stage II when R38 was assisted every night to remove her bra which would require daily visualization of the thoracic area by staff members. LPN6 responded, "Someone should have seen it." Record Review of documents for R38 with the title "Bath Skin Observation"(which is generated by the observations made by the nurse assistant (NA) during bath/showers) indicated that on 11/27/17, 12/4/17 and 12/11/17, R38 had no documented skin breakdown. On 12/18/17, the entry reflected red areas, bruise and dry/flaking skin on the "Bath Skin Observation" sheet. The document did not indicate the location of the redness and bruise. Record Review of R38's documents titled "Wound-Weekly Observation Tool" dated 12/19/17 (which is the first assessment of the thoracic pressure injury by the Wound Care Nurse (WCN)) indicated that the wound was acquired on "12/18/17" with the following assessments: location: "mid-thoracic spine, stage II, type: pressure, epithelial tissue present (pink), moist, no drainage or odor, length 1cm and a width of 1cm with no depth." The peri-wound tissue (which is the skin surrounding the wound) was described as "intact, redness stage 1 measures 3 x 2.5 cm." Under treatment, the same form indicated that the wound would be "covered with 2x2 dressing with tape and change daily." Under special equipment/preventative measures, "cushion to w/c [wheelchair]" was listed. This only alleviated pressure to the gluteal (buttock) area and not the thoracic spine area	F 686	infection and prevent new ulcers from developing Facility's wound nurse will enroll in a wound certification course to become a certified wound nurse. Facility will also utilize Senior Providers Resource Certified Wound Nurse for residents whom wish to stay in the building and not travel to local Mayo Clinic Hospital to utilize their wound nurse. Senior Providers Resource is licensed in the state of Minnesota; she will help establish new educational resources for nursing staff training. Staff education on provider notification policy in relation to change in condition and lab on 4.16.2018. Staff education on if follow up of lab results for timely start of ATBs. Education on follow up to provider of medication not in facility and use of emergency kit. Staff education about proper documentation in facility's electronic medical record. An audit will be performed during weekly wound rounds per facility policy and procedure. All results of audits will be reported to facility QAPI committee and the provider will be notified of any decline. Facility QAPI will review audit results for compliance. Director of Nursing is responsible for overall compliance. Completion date 4/26/2018.	

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F 686	Continued From page 31 where the pressure ulcer was located. Record Review of R38's documents with the heading of "Wound-Weekly Observation Tool" dated 12/26/17 indicated no changes to size, description nor preventative measures for thoracic pressure injury. Listed as treatment is: "cover with 2x2 foam dressing and tape, change qd [every day]. Barrier cream to intact surrounding skin." Record Review of R38's documents with the heading of "Wound-Weekly Observation Tool" dated 1/3/17 indicated a deterioration of the thoracic wound. It was noted by the WCN that the thoracic wound had "worsen[ing]" but the facility had incorrectly assessed this as remaining a Stage 2 wound. For the first time, "slough [devitalized tissue in a wound bed which interferes with the healing process]" was mentioned in the description of the thoracic wound. According to the International National Pressure Ulcer Advisory Panel's (NPUAP) Pressure Ulcer Classification System, a pressure ulcer changes from a stage 2 to a stage 3 or 4 when slough appears. At Stage 3, there is "Full thickness tissue loss. Subcutaneous fat (layer of tissue underneath the skin) may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss." The measurement documented 1/3/18 by the WCN of the thoracic wound increased to "1.5 cm x 1cm in length and width with no depth measurements." In the same wound assessment tool, infection was checked off with drainage	F 686		

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described as "purulent (pus) and small in amount" along with "inflammation." The Treatment and preventative measures portion of this document remained unchanged. No interventions were added nor treatment orders changed despite the signs of development of infection in R38's pressure ulcer.

Record review of nursing progress notes for R38 dated 1/5/18 at 10:35pm indicated, "Culture came back on resident's back. It is positive for staphylococcus Auroras (sic)." There was no documentation found that the nurse practitioner or physician were notified of the results that indicated infection.

Record review of a form titled "Laboratory Services Report" with a date and time printed as 1/6/18 at 9:55am included the final report of "Staphylococcus Aureus 3+" with sensitivity results which informs the health care provider which antibiotic therapy is appropriate. Review of R38's clinical progress notes, revealed no documentation indicating a health care provider (the Nurse Practioner or physician) was notified by facility nursing staff to obtain orders for treatment to address R38's infection.

Record review of the Nurse Practitioner's (NP) notes dated 1/9/18 revealed, R38 "is a (sic) 85 y.o. (year old) resident (name of facility) with Hypertension, CHF, (congestive heart disease) Stroke with right sided weakness, history of MRSA (methicillin-resistant staphylococcus aureus, a bacteria with antibiotic resistance) in a wound to her neck..." In addition, the notes include, "She is was (sic) recently found to have a staph infection to her mid thoracic area on her back...Will start Keflex 500mg by mouth 3 times a

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day for 10 days. Nursing staff to monitor closely." However, the order was not written by the NP, and the antibiotic was not started. This note was dated four days after the facility had obtained the culture results which showed an infection in R38's thoracic pressure injury.

Nine days after the facility received a culture of staphylococcus aureus infection to R38's thoracic area, as evidenced by record review of the nursing progress notes dated 1/14/18 at 2:12pm, the facility obtained the order for "Keflex Capsule 500mg (Cephalexin) Give 1 capsule by mouth three times a day for Staph infection for 10days."

An additional delay in the administration of Keflex was identified in R38's clinical record. Review of the nursing progress noted dated 1/15/18 at 9:27pm indicated, "This nurse discovered that there was no documentation on PCC (Point Click Care, the facility's electronic medical record) regarding the order for resident to receive Keflex 500mg TID (3 times a day) for 10 days. Called today's nurse for day shift and asked if she had given the med. She stated that she did not because there was none on the cart. Med (medication) error report completed..."

Record Review of facility's list of medications available for immediate use under the heading of "Emergency Medication Kit Usage Form" included Keflex (Cephalexin) 250mg 6 capsules. The facility had available Keflex 250mg 2 tablets (500mg) which could have been given to R38 for the first doses for R38 of the antibiotic but instead waited to administer the antibiotic to R38 on the next day.

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An interview was conducted with the NP over the phone on 3/29/18 at 4:14pm regarding R38. When asked if she recalled being notified of R38's staphylococcus aureus infection, the NP replied that she was "probably notified on 1/14/18." The NP was asked to recall her visit and examination of R38 on 1/9/18. The NP's notes dated 1/9/18 stated, "Reason for Visit," under "Wound Lower Back Open Initial" indicated, "Will start Keflex 500mg by mouth 3 times a day for 10 days." The NP was asked as to why the Keflex was not started on that day. The NP replied, "I might have not written it."

During an interview with the WCN on 3/28/18 at 2:50pm, the WCN was asked how laboratory results are relayed to the physician. The WCN offered the following explanation: The floor nurses receive the results by fax, and it is reported to the Nurse Practitioner, if abnormal. If a medication is ordered, it is placed in the computer. Laboratory results such as positive cultures are reported or a copy is given to her. When the WCN was asked about the delay in giving the abnormal culture results to the Nurse Practitioner, the Wound Care Nurse stated that she was on vacation during the time of 1/7/18, and she was unclear as to why the positive wound culture of staph was not addressed.

Record review of nursing progress notes dated 1/20/18 for R38 indicated, "Resident spends much of her day sitting in recliner, resident is encouraged to lie down after lunch to reduce pressure."

During an interview and observation conducted on 3/27/18 at 8:56am, R36 was sitting up in her chair with no pressure alleviating devices

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F 686	Continued From page 35 between her back and the back of her chair. While in R38's room on 3/28/18 approximately at 10:40 am, LPN5 was asked about the pressure alleviating properties of R38's mattress. LPN 5 verified that R38 had a regular mattress and not a pressure alleviating mattress which would reduce the pressure to the thoracic wound when R38 is in bed. Again, R38 was observed sitting up in her recliner with no pressure alleviating device between her pressure ulcer on her back and the back of her chair. An interview was conducted with the WCN on 3/28/18 at approximately 1:30 pm regarding facility use of pressure alleviating devices for residents with pressure ulcers. When the WCN was asked who determines which resident receives pressure reducing mattresses, the WCN replied that the Resident Care Coordinators make that decision. During an interview with the LPN6, a Resident Care Coordinator, on 3/28/18 at 2:15pm, this Resident Care Coordiantor was asked what type of residents receive pressure reducing mattresses. She replied that residents who are heavy, prone to skin breakdown and not able to be repositioned are selected for this type of mattress. When asked who decides which resident receives a pressure reducing mattress, this Resident Care Coordinator replied" the nurses on the floor.' During an interview on 3/29/18 at 12:30pm with LPN5, a nurse who works on the floor with the residents, LPN5 was asked who determines which residents receive a pressure reducing mattress, LPN5 answered the "head people."	F 686		

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LPN5 was asked what measures were in place specifically for R38. LPN5 stated that R38 likes to be in the recliner and stays in the recliner up to 8 hours. When asked about releiving pressure on R38's wound on her spine, LPN replied that R38 is "off loaded" when assisted to the bathroom."

Review of "Wound Management" by the Wound, Ostomy and Continence Nurses Society, copyrighted 2016 on pages 364-374 indicates, In most situations, pressure redistribution is the most important feature of the support surface; effective pressure redistribution reduces the intensity of the pressure and extends the time he patient can safely remain in one position...The most important component of a support surface is the medium used to provide pressure redistribution...All patients with existing ulcers should be placed on a surface that provides an effective level of pressure redistribution (e.g., high-density foam, low-air-loss, alternation pressure, viscous fluid, or air-fluidized surface."

Review of the National Pressure Ulcer Advisory Panel's titled "Prevention and Treatment of Pressure Ulcer: Clinical Practice Guideline, second edition, 2014, under the heading of "How Tissues Respond to Different Types of Mechanical Loading," indicates, "The primary cause of pressure ulcers is a sustained mechanical load, (includes "all types of force that are applied to an individual's soft issue as a result of contact between skin and a solid surface) that is applied to soft biological tissues, generally near a bony prominence...The magnitude of the mechanical load that will lead to tissue damage depends on the duration of time for which the load is applied. In the same guidelines, under the heading of "Additional Recommendation for

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Individuals with Existing Pressure Ulcers, it is indicated, "Do not position an individual directly on a pressure ulcer...Position the individual off area(s) of suspected deep tissue injury...Continued pressure on an existing pressure ulcer will delay healing and may cause additional deterioration."

An interview was conducted with NA5 on 3/29/19 approximately at 1:00pm who has cared for R38. NA5 was asked what skin care measures were being implemented for R38. NA5 stated that lotion is applied to the skin and that she reports any drainage from the dressing to the back. NA5 did not include any interventions that included repositioning or use of a pressure relieving cushion behind R38's back when in her recliner. When NA5 was asked on how special needs of a resident is communicated, NA5 referred to a form known as "Care Manager Sheets" or "Nursing Aide Sheet" which is updated every Friday by LPN6 or the Medical Record Secretary, (MR)1. NA5 was asked for a copy of the most recent Nursing Aide Sheet. This was reviewed, and Under General information regarding R38, there were no interventions listed regarding R38's thoracic wound or what the nursing assistants were to do in order to relieve pressure over R38's wound.

On 3/28/18 and 3/29/18 at approximately 10:30am LPN5 was observed while changing the dressing to R38's thoracic wound. It was observed that the thoracic wound had pale yellow slough that completely covered the wound bed with reddish to purplish surrounding tissue. LPN5 stated that the thoracic wound had "worsen" (worsened). After the dressings were changed on both days, it was observed that the LPN5 did not

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F 686	Continued From page 38 place a pressure alleviating device behind R38's back. It was observed that R38 would lean back into the recliner after each dressing change. Record Review of R38's most recent document with the heading of "Wound-Weekly Observation Tool" dated 3/26/18 indicated a "worsening" with "slough" and "moderate" amount of "serosanguinous" drainage noted by the WCN. The size had increased in length to "4.1 cm" and a width of "2.3 cm" and a depth of "0.1 cm." The peri-wound tissue had increased to "8 x 6 purple blanchable area." Under evaluation of the wound progress, it indicated that the wound was "slightly larger, will change treatment when supplies arrive." Review of the "Wound area/Size Trend" dated 3/26/18 under wound etiology indicated, "Pressure Ulcer-Unstageable." Further review of the same document indicated the following wound measurements and PUSH Score: 1/24/2018 1.10cm X 1.00cm Area 0.86 Push Score 7 2/26/2018 1.60cm X 0.90cm Area 1.13 Push Score 7 3/15/2018 3.20cm X 2.80cm Area 7.03 Push Score 7 3/26/2018 4.10cm X 2.30cm Area 7.40 Push Score 13 PUSH SCORE- Changes in the score over time provide an indication of the changing status of the ulcer. If the score goes down, the wound is healing. If it gets higher, the wound is deteriorating. For this particular wound the latest score was 13 from 7 which indicated the wound deteriorated.	F 686		

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During an interview with WCN, a Registered Nurse (RN) who coordinates the facility's wound program, on 3/28/18 at 4:04pm when asked about her training, the WCN responded, "I never had any formal training, only what I learned from nursing school, but we have a nurse consultant that comes once a month." The WCN further stated that the "nurse consultant" accompanies her during wound rounds and decides which treatment would be best for wounds. WCN also stated that she relies on the guidance provided by this "nurse consultant" for selecting treatment options which in turn were used as the basis for physician orders.

An interview was conducted over the phone on 3/29/18, at approximately 8:15am, with the person designated as the 'nurse consultant" by the facility's WCN. When the "nurse consultant" (now referred to as Durable Medical Equipment Representative, DME Rep) was asked about her role in wound care for the facility and her credentials, the DME Rep stated, "I am not their (referring to the facility) wound care consultant. I am a LPN (licensed practical nurse). I do not have any wound certification and my training was through my employer [the durable equipment company]... I do not assess... I do data collection." When asked on who decides on treatment, DME Rep responded, (first name of the WCN from the facility) and I decide... and what is appropriate secondary to assessment."

An interview was conducted with the Administrator, DON and facility WCN on 3/29/18 at 4:20pm. When Administrator, DON and WCN were told of the phone interview with the DME Rep, they responded that they believed that

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(name of the DME Rep) was an RN and wound care certified. The DON added, "We depended on (first name of the DME Rep)."

During this same interveiw, the Care Plan for R38 was reviewed with the DON, and the DON was asked if he could identify any interventions in the Care Plan regarding R38's thoracic wound which was first detected on 12/18/17. The DON replied, "Looks like we haven't been monitoring..." The DON was then asked to review the Nursing Aide Sheet for R38 and was asked to identify interventions regarding the care of R38's thoracic wound, and the DON replied, "No interventions. Does not address how to care for back." When asked as to why there was a delay in R38's receiving the Keflex, the DON could not answer as to why. The DON was presented with findings that the wound care treatment was being decided by a representative of a dressing supply company, there was an extended delay by the facility in notifying the NP of a positive wound culture for infection, there was a delay by the facility in the administration of antibiotics for R38's wound infection, and that no interventions were in place to alleviate pressure on R38's wound, and that acquired wound infection was not included in R38's Care Plan and Nursing Aide Sheet. When asked if R3's wound would have been avoidable, th DON replied, "Not sure."

During an interview on 03/29/2018 at 7:21pm, the Nurse Practitioner (NP) said, "[I] did not know the DME Rep was not certified in wounds." She also said, "I noticed several residents' wounds were not improving and decided to send them out to the wound clinic to be evaluated." The NP further stated, "The facility did not communicate with me regarding DME Rep's credentials," and she had

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not checked on them herself. The NP said, "From now on all residents will be sent to the wound clinic until we get this matter cleared up." The NP also said, "Our residents deserve better than this."

Review of the facility's undated Policy and Procedure titled "Comprehensive Skin Condition Policy" revealed, "Policy...residents will have risk factors for skin breakdown assessed, and individualized care planning measures taken to prevent skin breakdown. In the event skin breakdown does occur, residents will receive the appropriate intervention, notification of concerned parties, treatment and re-assessment to ensure future episodes/complications are eliminated or minimized... Purpose: To ensure residents receive the appropriate care to ensure their maximum level of physical and psychosocial well-being by preventing skin breakdown and/or related complications."

Review of the article titled "Using Device for Pressure Ulcer Prevention and Treatment" by Evan Call, MS and Joyce Black, PhD, RN, CWCN, FAAN in dated 2015 in www.npuap.org's website, indicates, "Pressure ulcer form due to pressure, therefore redistributing pressure is the most important component of care. Ongoing pressure will delay healing and increase the risk of further ulceration."

According to a research titled "Certification and education: do they affect pressure ulcer knowledge in nursing?" dated January 2007 from https://www.ncbi.nlm.nih.gov/ revealed, "OBJECTIVE: To determine whether wound care certification and education affect nursing knowledge. This study examined pressure ulcer

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F 686	Continued From page 42 knowledge among registered nurses who were (1) certified in wound care, (2) certified in specialty areas other than wound care, or (3) not certified in any specialty area...CONCLUSION: Wound care certification and education significantly affect nursing knowledge."	F 686		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure weights were conducted per the facility policy for one (R60) of 49 sampled residents, who was a new admission. The facility failed to implement interventions timely when weight loss was identified for R60 to prevent	F 692	It is the policy of Lakeview Care Center to obtain weights on all new admissions. Resident # R60 has been set-up on weekly weights. The Registered Dietitian has reviewed the medical record. All nursing staff have been educated on	4/26/18

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F 692	Continued From page 43 further weight loss. Findings Include: Review of the "Physicians Orders" for R60 dated March 2018 revealed the resident was admitted to the facility on 2/07/18 with diagnoses that included fracture of the right femur and diabetes Type 2. The "Admission Assessment" dated 2/07/18 for R60 failed to reflect an admission weight was obtained. The space entitled "Weight" was left blank. The "Medication Review Report" dated 2/07/18 for R60 identified a "No Added Salt" (NAS) diet and Furosemide (Diuretic) 20mg (milligram) in the morning related to atherosclerotic heart disease. The care plan for R60 dated 2/08/18 identified the resident has a nutritional problem with interventions that included, "provide meal as ordered, monitor meal intake, and provide finger foods." The "Nutrition/Dietary Note" dated 2/08/18 for R60 identified the resident "was admitted yesterday following a hospitalization for a fall with a right hip fracture. He is on a NAS diet. No chewing or swallowing problems. He fed himself after set up help was provided, and he ate 51-75%. Height is 70 and Ideal Body Weight (IBW) range is 149-183 lbs. (pounds). He has not yet been weighed since admission. Braden score low at 16. For his diabetes we will provide him with sugar free condiments and half portion desserts. Will consider nutrition interventions for his skin after further review of his meal intakes.	F 692	obtaining weights on new residents upon admission and daily for the following two weeks. Staff educated on 4/17/2018. An audit will be performed daily on all new admissions to confirm that admission weights are being performed as per facility policy and procedure. All results of audits will be reported to facility QAPI committee. Facility QAPI will review audit results for compliance. Director of Nursing is responsible for overall compliance. Completion date 4/26/2018.	

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F 692	Continued From page 44 Wrote initial care plan for nutritional status..." The care plan dated 2/12/18 identified R60 is on diuretic therapy related to altered cardiovascular status with interventions that included to "administer diuretic medications as ordered by physician." The Admission Minimum Data Set (MDS), a comprehensive physical and psychosocial assessment, dated 2/13/18 for R60 identified a Brief Interview for Mental Status (BIMS) of 15 (intact cognition), independent eating with set up and weight of 159 lbs. Review of the "Weights and Vitals Summary" for R60 identified a weight of 158.9 lbs. on 2/13/18. The "Nutrition/Dietary Note" dated 2/15/18 for R60 documented: "Reviewed his intake since admission, noting many meals in the 25-75% range, both during and since his assessment period. Admission weight was 158.7 lbs., above the weight of 154.0 lbs. documented on hospital History and Physical. The higher weight is most likely due to continued post-operative edema." The "Nutrition/Dietary Note" dated 2/26/18 for R60 documented "his intake is variable and will contact nursing tomorrow and recommend "Glucerna", a nutritional supplement, 4 ounces BID (two times a day." Review of the "Weights and Vitals Summary" identified a weight of 148.8 lbs. on 03/08/2018 for R60 (sitting) a 6% weight loss, and a weight of 140.8 lbs. on 3/17/18 (mechanical lift) a 11% weight loss.	F 692		

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F 692	Continued From page 45	F 692		

The "Nutrition/Dietary Note" dated 3/14/18 for R60 identified an "unplanned weight loss and will refer to LD (licensed dietitian - the MDS Coordinator) on next visit."

Review of the "Weights and Vitals Summary" identified a weight of 140.9 lbs. on 3/22/18 for R60. There was no indication if this weight was sitting or with a mechanical lift scale.

The "Nutrition/Dietary Note" for R60 dated 3/27/18 identified chronic diagnoses include diabetes type 2, chronic pain syndrome, history of falls. He is now also referred for weight loss. He is on a NAS diet, with care planned interventions in place for his diabetes (sugar free condiments and fruit for dessert per his preference) He eats in the 1st floor E DR (dining room), can feed himself after set up help is provided. His intake has improved since my last review in late February, with 12 meals out of 22 in the past week at 76-100%, another 5 meals at 51-75%, 4 meals at 26-50%, and just 1 meal at 0-25%. He has previously told me that his usual weight at the clinic is 161-163 lbs., but his weight documented on his "History and Physical" (H&P) on 1-30-18, prior to his hip surgery, was about 154 lbs. We have orders for 4 ounces Glucerna BID and a multivitamin daily. Will recommend requesting an increase in his Glucerna to 8 ounces BID."

Interview with the Assistant Director of Nurses (ADON) on 3/30/18 at 12:15pm identified the facility policy is to weigh residents on admission and weekly for two weeks thereafter. The ADON looked through the weekly weight sheets, record, and daily report sheets for documentation the resident was weighed per the facility policy, but was unable to locate any further documentation.

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F 692	Continued From page 46 The ADON could not explain why interventions were not implemented until 3/27/18 when a 6% weight loss was noted on 3/08/18 and on 11% weight loss on 3/14/18. Review of the "Weight Assessment and Intervention" policy states "The nursing staff will measure a resident weight on admission, and weekly for two weeks thereafter. If no weight concerns are noted at this point, weights will be measured monthly thereafter."	F 692		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under	F 725		4/26/18

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F 725	Continued From page 47 paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide sufficient and competent nursing staff to assure the needs for five (R2, R16, R53, R57 and R65) of 49 sampled residents were met to achieve the highest practicable level of well-being. The facility failed to ensure adequate assistance with activities of daily living (ADLs). Findings Include: 1. During an interview on 3/26/18 at 4:35pm, R2 said there was always a 15 to 20-minute wait for the staff to answer her call light. She said there were times she waited 45 minutes to an hour for assistance. R2 said she often had to use the call light in the middle of the night and she would have an "accident [urination]" in her bed while she waited for staff to come and help her. She stated she needed staff's assistance to get out of bed and use the bathroom. Review of the annual "Minimum Data Set" (MDS), a comprehensive assessment tool completed by the facility staff, dated 8/10/17 indicated R2 was cognitively intact with a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15. Review of the same MDS revealed that R2 needed an extensive assistance of one person with toileting. 2. R57's "Physician orders" dated March 2018 identified diagnoses that included dementia with behavior disturbances and rheumatoid arthritis. R57 resided on the second floor.	F 725	Facility's staffing policy and facility assessment have been reviewed. Staffing patterns have been reviewed and are within industry standards. Currently our staff scheduling runs at a 3.79 ppd. Director of Nursing and Administrator met with Resident council on 4.16.2018 and explained our process of hiring new staff and the facilities staffing. Call light policy and procedure was reviewed. Facility is actively working with building architect for a new updated call light system that will have the capabilities of producing electronic reports. Currently the system does not have this capability. Scheduler has been instructed to fill Nurse Aide call ins with licensed staff as needed. A call light audit will be completed daily x 2 weeks and then 3 x week, and PRN for one quarter; for the next 3 weeks to monitor staff wait response and resident wait times. During call light audits, anything over 5 minutes will require an explanation from auditor. All results of audits will be reported to facility QAPI committee. Facility QAPI will review audit results for compliance. Director of Nursing is responsible for overall compliance.	

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F 725	Continued From page 48 The MDS assessment dated 2/14/2018 identified a BIMS of 15 of 15 (intact cognition), and extensive assistance of one person with toileting. During an interview on 3/27/18 at 11:14am, R57 stated the facility did not have enough staff to take her on and off the toilet timely. R57 indicated that 2 weeks ago on the evening shift, she waited approximately 45 minutes after ringing the call light for a staff member to respond. R57 stated the long response time is common. R57 indicated staff state they are delayed in responding to the call light because they are busy with other residents. 3. During an interview on 3/26/18 at 5:10pm, R65 said, "The facility was usually short staffed." R65 further stated, "The staff leave me waiting for help often." She also stated, "At times, I waited for an hour for help going to the restroom." R65 also stated, "I recently had a bladder infection and it made my urgency worse. It was difficult to wait for the staff during this time because it took them so long to respond to my call light." R65 further stated, "The staff told me it was because they were short staffed." Review of the annual MDS dated 01/10/2018 indicated R65 was cognitively intact with a BIMS score of 15 out of 15. Review of the same MDS revealed that R65 needed an extensive assistance of two or more persons with toileting. 4. Record review of R16's document with the heading of "Admission Record" included the following diagnoses: osteoarthritis, urinary incontinence, history of falling and anxiety disorder.	F 725		

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F 725	Continued From page 49	F 725		

Record review of the most recent quarterly MDS dated 12/27/17 indicated that R16's BIMS was completed. A Score of 8-12 indicated that there was a moderate of impairment which R16 scored a 10.

Record review of the same quarterly MDS revealed in "Section G - Functional Status under G0110 Activities of Daily Living (ADL) Assistance, I. Toilet Use" indicated that resident required "Extensive assistance - resident involved in activity, staff provide weight-bearing support with One person assist."

During an interview conducted 3/27/18 at 2:50 pm, R16 was sitting up in chair and was able to appropriately answer multiple initial pool questions. When R16 was asked about how long it took for staff to answer the call light when the need was to go to the bathroom, R16 veered away from yes and no answers. R16 replied that the long wait caused her/him to "wet" herself/himself which caused an "embarrassment."

5. Record review of the most recent quarterly MDS dated 1/31/18 indicated that R53s was completed. R53's score was a 00 because R53 could not complete the interview. Record review of the same MDS indicated R53 needed an extensive assistance of two or more persons with toileting.

An interview of a Family member (Z2) was conducted over the phone on 3/29/18 at 10:17am. Z2 stated that it took long periods of time for call lights to be answered. When Z2 was asked how long it took, Z2 replied that there were

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F 725	Continued From page 50 "lots of incidences of a 45 minute wait." 6. Interview of Nursing Assistant (NA)1 on 3/27/18 at 9:45am stated there was not enough nurse aides to get all the care done. NA1 stated she was the only CNA (certified nursing assistant) on the hall and she cannot help residents in the dining room and help residents who stay in the rooms at the same time. NA1 stated since the facility took residents from another facility it has been difficult to do all the work. NA1 worked on the second floor South wing with 10 residents. 7. Interview with a Family Member (Z)1 on 3/29/18 at 11:12am identified R126 was a dependent resident who was not interviewable and who resided on the second floor. Z1 stated she had concerns about staffing, and feels that more staff are needed. Z1 stated she would like for R126 to get up earlier but the staff are always busy and cannot get her up. 8. During a confidential group interview on 3/28/18 at 10:00am, all the residents in attendance said they had experienced longer than 15-minute wait times for their call light to be answered. The group remarked about being left in the lift device, an EZ stand (device that assists them to the toilet) for up to an hour. Several of the residents said the staff will tell you they would "be right back" and they never return. Some residents commented that they had accidents while waiting for staff to assist with toileting. The consensus of the residents who attended the group interview was the facility was short staffed. Residents stated they had reported staffing issues to the "nurse." 9. Review of a "Grievance/Resolution Form"	F 725		

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F 725	Continued From page 51 dated 12/12/17 indicated a family member (unidentified) complained to the facility about a nurse's aide saying she did not have time to talk because she was trying to get her work done. According to the form, the facility followed up with the nurse aide and she said if she visited with the family she would not have time to get her work done. 10. Review of a "Grievance/Resolution Form" dated 10/17/17 indicated a resident complained to the facility of long call light wait times. (No specific time or staff member). Interview of the Director of Nursing (DON)on 3/30/18 at 3:40pm, the DON stated that three years ago a company came in to the facility to look at number of hours the facility needed per resident. The facility scheduler knows the number of licensed and nonlicensed staff that are needed and the schedule is based on that number. The DON stated he did not use the "Facility Assessment" to determine staff ratios but looks at acuity of the residents. The DON stated when CNA 's believe they are short they report it to him and he tries to up the staff but it was difficult to find CNA's. The DON stated that the facility did take residents from a nursing home that closed but they also hired staff to ensure the par levels were maintained.	F 725		
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, but are not limited to, drugs in the following	F 758		4/26/18

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F 758	Continued From page 52 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 drugs are limited to 14 days and cannot be	F 758		

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F 758	Continued From page 53 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 record review and interviews the facility failed to ensure one (R126) of 49 sampled residents was free of unnecessary medications. The facility failed to ensure Antipsychotic medication was not administered without adequate rationale for use. Findings Include: Review of the "Physicians Orders" dated March 2018 for R126's revealed diagnoses to include dementia without behavior disturbances and anxiety disorders. The "Physician orders" dated 2/21/18 directed R126 be administered Seroquel 12.5 mg (milligrams) in the evening for agitation. The Minimum Data Set (MDS) dated 3/1/18 for a Significant Change, a comprehensive resident assessment, identified a BIMS (cognitive assessment) score of 0 and the staff interview for cognition was not conducted. The MDS further identified screaming, cursing, hitting, pushing, kicking behaviors occurred four to six days a week and received and antipsychotic and antidepressant medication during the last seven days. The care plan dated 3/12/18 identified the resident uses a psychotropic medication for refusal of care, and anxiety disorder with interventions that included to consult with pharmacy, and the Medical Doctor for dosage	F 758	R126 on 3/28/2018 received a diagnosis of unspecified dementia with behavioral disturbances, due to resident's refusal of cares, physical and verbal aggression, from resident's hospice organization. This facility educated resident care coordinator and hospice organization on the need for timely diagnosis for a psychotropic medication on 4/17/2018. Facility will continue to work with consulting pharmacist, who provided the facility with an updated State approved diagnosis list. Resident care coordinator and hospice were educated on State approved diagnosis list for psychotropic medications. An audit will be performed monthly on all psychotropic medications, for all residents, as per facility policy and procedure. Prior to giving facility will require an approved diagnosis for all psychotropic medications, for all resident. All results of audits will be reported to facility QAPI committee. Facility QAPI will review audit results for compliance. Director of Nursing is responsible for overall compliance. Completion date 4/26/2018.	

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F 758	Continued From page 54 reduction when clinically appropriate, at least quarterly. Monitor and document refusals of care, and monitor and report any adverse reactions. The "Pharmacy Consultant review and recommendation" dated 3/20/18 identified the resident was receiving "Seroquel for agitation and please re-assess the need for Seroquel and provide appropriate indication and documentation or discontinue." Interview with Licensed Practical Nurse (LPN)2 on 3/28/2018 at 9am identified the resident began on Seroquel 12.5mg on 2/21/18 for dementia without behavior disturbances. LPN2 stated the Assistant Director of Nurses (ADON) was the person at the facility who followed through on Pharmacy Consultant recommendations. Interview on 3/28/18 at 2pm with the ADON identified the Pharmacy consultant emails the recommendations to the facility after the review was conducted. The ADON stated "It is my responsibility to follow up on the recommendations with the physician." The ADON stated "The Seroquel was ordered by the Hospice physician and it was the responsibility of the contracted Hospice nurse to obtain the diagnosis for the use of Seroquel." The ADON stated she did not yet informed the Hospice nurse of the Pharmacy Consultants recommendation.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources	F 812		4/26/18

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F 812	Continued From page 55 approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed ensure food was prepared and served under sanitary conditions to include dishware and food preparation equipment stored unclean, staff did not fully secure their hair with hairnets during food service, hand hygiene was not performed and food items were stored in open containers. Findings Include: During an observation on 3/26/18 at 3:35pm there were multiple pieces of dishware and food preparation equipment was stored on an open shelf with food debris on the surface including: two thickener bottles, one dessert cup, and one glass bowl. A metal pan that held scoops was stored in a cabinet that had dust and food debris inside. The shelves of the storage cabinet had dust and food debris. A plastic container of instant potatoes was	F 812	Shelves, mixer head, spray hoses, toasters, and all other areas in kitchen will be re-examined and re-cleaned from 04/23 through 04/26/18. A new cleaning policy with specific job assignments will be developed by Dietary Director and staff will be educated on 04/26/18. Dietary Director will monitor and log compliance weekly x 3 months and report to QAPI team. A new policy for checking clean dish rack has been developed by Dietary Director and Dietary staff were educated on 04/23/18. The Dietary Director will review all policies on hand washing, glove usage, and hairnets will be reviewed with all dietary staff on 04/20/18 and 04/23/18, and with all staff on 04/26/18. Dietary Director will monitor and log compliance weekly x 3 months and report findings to QAPI. Completion date 4/26/2018.	

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F 812	Continued From page 56	F 812		

open and stored in a cabinet. The large mixer head was dirty with food debris. The drink nozzle on a spray hose for honey and nectar thick liquid was dirty with residue. The knobs and dials on the toaster were dirty with food debris. A plastic container with potato salad was stored in the large refrigerator with a broken lid and the potato salad was exposed.

During an observation on 3/28/18 at 8:55am a maintenance staff was in the kitchen without a hair net. The dietary staff were preparing the lunch meal. All five of the dietary aides present did not have their hair fully contained in their hairnets.

During an observation on 3/28/18 at 9:05am here was dried food debris present on the following items stored in the clean dish rack: two compartmented plates, one butter dish, one dessert bowl, three clear dessert cups, two ceramic cereal bowls, and one small glass cup.

Observation continued 3/28/18: The butter dish also had a hair inside of it. The container of instant potatoes stored in the cabinet was still open.

During an observation on 3/28/18 at 4:40pm a standing fan was present with dust on its cover, blowing throughout the kitchen.

During an observation on 3/28/18 at 5:15pm a volunteer entered kitchen without hairnet to throw trash away. Three dietary staff did not have their hair fully contained by the hairnet. During the meal service Dietary Aide (DA) 1 discarded three bowls because there was food debris or moisture present. DA 2 and DA 3 went into the dining

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room several times and returned without washing their hands. DA 2's facial hair was uncovered. DA 2, with gloved hands, went upstairs in the elevator, came back to the kitchen, touched the trashcan lid, and resumed plating food from the steam table without changing his gloves and washing his hands.

During an interview on 3/29/18 at 1:51pm when asked about the dishware that was stored with food particles still present, the Dietary Manager said there were no problems that she knew of with the dishwasher. She said the staff get in a rush and overfill the trays going into the dishwasher and that can cause food debris to remain on the dishes. She said she expected her staff to inspect the clean dishes to ensure they were clean. She said the staff could have part of their hair uncovered by their hairnets. She said all the unclean items found during kitchen observations should have been clean.

Review of a "Grievance/Resolution Form" dated 1/18/18 indicated a resident had found a hair in the main course of their meal.

Review of the undated "Infection Control/Dietary" policy indicated "all personnel working with the preparation, service and storage of food, cleaning of kitchen areas and during washing dishes will wear hairnets or caps. Hairnets will cover pony tails when hair is pulled back tightly. Three to four inches of bangs/hair will be allowed to be uncovered." The policy also indicated "hands must be washed upon entering the kitchen and each time they are contaminated."

Review of a "Sanitation" policy dated 10/2008 indicated "the food service area shall be

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F 812	Continued From page 58 maintained in a clean and sanitary manner and all utensils, counters, shelves and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seams, cracks and chipped areas that may affect their use or proper cleaning." The policy further indicated "all equipment, food contact surfaces and utensils shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized."	F 812		
F 840 SS=G	Use of Outside Resources CFR(s): 483.70(g)(1)(2) §483.70(g) Use of outside resources. §483.70(g)(1) If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (g)(2) of this section. §483.70(g)(2) Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for- (i) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and (ii) The timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure outside wound care services met professional standards and	F 840	Facility's wound nurse will enroll in a Wound Certification course to become a Certified Wound Nurse. Facility will also	4/26/18

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F 840	Continued From page 59 principles.This failure affected two (R38 and R8) of six residents reviewed for wound care services in the sample of 49 and resulted in actual harm for one (R38) resident. Findings include: According to a research titled "Certification and education: do they affect pressure ulcer knowledge in nursing?" dated January 2007 from https://www.ncbi.nlm.nih.gov/ revealed, "OBJECTIVE: To determine whether wound care certification and education affect nursing knowledge. This study examined pressure ulcer knowledge among registered nurses who were (1) certified in wound care, (2) certified in specialty areas other than wound care, or (3) not certified in any specialty area...CONCLUSION: Wound care certification and education significantly affect nursing knowledge." 1.Review of R38's "Admission Record" dated 5/22/17, indicated R38 had admitting diagnoses that included but were not limited to right hand contracture, hemiplegia (paralysis of one side of the body) and unspecified sequelae of cerebral infarction (stroke). On 3/28/18 at approximately 10:30am, Licensed Practical Nurse (LPN5) was observed to provide wound treatment to R38's mid- thoracic spine pressure ulcer. LPN5 was asked about the status of the wound. LPN5 stated, "It's worsening it used to be dime size now it's bigger." LPN5 further stated, that the wound became infected "a couple of months ago." Record review of R38's quarterly MDS assessment dated 1/31/18 under "Section	F 840	utilize Senior Providers Certified Wound Nurse for residents whom wish to stay in the building and not travel to local Mayo Clinic Hospital to utilize their wound nurse. Facility will offer local wound nurse option from Mayo Clinic Health Systems-Fairmont for immediate wound care needs. All wounds will be reviewed by primary NP/MD. Senior Providers Resource is licensed in the state of Minnesota; she will help establish new educational resources for nursing staff training. Wound nurse will round with Resident Care Coordinator and floor nurse to ensure communication amongst staff. An audit will be performed during weekly wound rounds per facility policy and procedure. All results of audits will be reported to facility QAPI committee and the provider will be notified of any decline. Facility QAPI will review audit results for compliance. Director of Nursing is responsible for overall compliance. Completion date 4/26/2018.	

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F 840	Continued From page 60 M0300. Current Number of Pressure Ulcers in each Stage" indicated, "...B. Stage 2 Partial loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough...number of Stage 2 pressure ulcers was coded 1, 2.Number of these Stage 2 pressure ulcers that were present upon admission/ reentry was coded (0) which indicated that this wound was facility acquired..." Review of R38's most recent "Wound area/Size Trend" dated 3/26/18 under wound etiology indicated "Pressure Ulcer-Unstageable." Further review of the same document indicated the following wound measurements and Pressure Ulcer Scale for Healing (PUSH) Score: 1/24/2018 1.10 X 1.00 Area 0.86 Push Score 7 2/26/2018 1.60 X 0.90 Area 1.13 Push Score 7 3/15/2018 3.20 X 2.80 Area 7.03 Push Score 7 3/26/2018 4.10 X 2.30 Area 7.40 Push Score 13 Note that above measurement were in centimeters (cm). PUSH SCORE- Changes in the score over time provide an indication of the changing status of the ulcer. If the score goes down, the wound is healing. If it gets higher, the wound is deteriorating. For this particular wound the latest score was 13 from 7 which indicated the wound deteriorated. On 3/28/18 at 4:02pm the Wound Care Nurse (WCN), a Registered Nurse (RN) who coordinates the facility's wound program, was asked about R38's mid-thoracic spine pressure ulcer. The WCN stated that it was already a Stage 2 pressure ulcer when it was discovered on 12/19/17 that it deteriorated and became unstageable. When asked what training she had	F 840		

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on wound care, the WCN stated, "I never had any formal training, only what i learned from nursing school but we have a nurse consultant that comes once a month." The WCN further stated that the nurse consultant (referring to the Durable Medical Equipment Representative - DME Rep) looked at the wound during wound rounds and decided what would be the best treatment for the wound. The WCN then related these recommndations to the physician to obtain the treatment order.

2. Review of the "Physician's Orders" for R8 dated March 2018 revealed R8 was admitted to the facility on 1/19/17 with diagnoses including type II diabetes, diaper dermatitis (skin inflammation), and congestive heart failure.

Review of the annual "Minimum Data Set" (MDS) a comprehensive assessment tool completed by the facility staff, dated 12/20/17 indicated R8 needed extensive, two persons assist with transfers and positioning. R8 also utilized a wheelchair for mobility. R8 was cognitively intact with a "Brief Interview for Mental Status" (BIMS) score of 15 out of 15.

During an observation on 3/28/18 at 11:30am with WCN, R8's right and left buttock had an area of purple colored skin. The discolored area measured 13.0 centimeters (cm) x 13.0 cm, when measured by the WCN, (the right and left buttock areas were measured together). There were three open areas noted on the right buttock that measured 0.5 cm x 1.0 cm; 0.8 cm x 1.0 cm; and 0.2 cm x 0.2 cm. WCN applied Zinc Oxide (a cream used to treat diaper rash, minor burns, severely chapped skin, or other minor skin irritations) to the areas prior to replacing the

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disposable brief. WCN documented that the open areas on R8's buttocks were new. The areas were open but was unable to provide a depth measurement.

Review of the wound assessment per the "Weekly Wound Observation Tool" dated 3/28/18 revealed the same measurements as noted above with no measurable depth of the open areas.

Review of the care plan dated 5/01/17 indicated R8 required assist by one staff to turn and reposition. R8 was care planned to have incontinent care every two hours and as needed.

Review of the "Wound Care Skin Integrity Evaluation" dated 10/27/17 indicated R8's wound was assessed, measured, described and this was signed by the DME Rep.

Review of the "Wound Care Skin Integrity Evaluation" dated 3/14/18 indicated R8's wound was assessed by the same DME Rep.

During an interview on 03/28/18 04:23 PM the WCN said that the DME Rep had assessed the resident's wounds periodically up until 3/22/18 when R8 was sent out to the wound clinic.

On 3/29/18 at approximately 8:15am, the DME Rep was asked what her role was in the facility's wound care program. The DME Rep stated that she was a clinical specialist and her role was to provide education to the facility staff about wound care products provided to residents by her employer American Medical Technologies (AMT). The DME Rep explained, "I am not their [referring to the facility] wound care consultant. I am a

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licensed practical nurse [LPN], I cannot assess, I do not have any wound care certification and my training was through my employer." The DME Rep further explained that the training was focused on their products that were used by the residents and billed directly to Medicare Part B. When asked about her signed assessments forms, the DME rep confirmed that those assessments were taken from the WCN's "Weekly Wound Observation Tool" and the form that she completed was for AMT and for billing purposes.

On 3/29/18 at approximately 4:20pm, the Director of Nursing (DON), the Administrator and the WCN were interviewed about the facility's wound care program. When asked about the wound care nurse consultant [referring to the DME Rep], the WCN and the DON stated that they both believed the DME Rep had wound care certification. When told about the conversation with the DME Rep at 8:15 that morning, the WCN and the DON stated that they assumed the DME Rep was an RN with wound care certification and that they always considered her as the facility's wound care nurse consultant. The DON confirmed that he had not checked the DME Rep's credentials.

During an interview on 3/29/18 at 7:21pm, the Nurse Practitioner (NP) said, "[I] did not know the DME Rep was not certified in wounds." She also said, "I noticed several residents' wounds were not improving and decided to send them out to the wound clinic to be evaluated." The NP further stated, "The facility did not communicate with me regarding DME Rep's credentials" and she had not checked on them herself. The NP said, "From now on all residents would be sent to the wound clinic until we get this matter cleared up." The NP

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F 840	Continued From page 64 also said, "Our residents deserve better than this."	F 840		
F 880 SS=F	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 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;	F 880		4/26/18

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F 880	Continued From page 65 (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 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 record review, the facility failed to: establish and implement a comprehensive surveillance plan based on the facility assessment which had the potential to affect all 71 residents in the facility at the time of survey; post the required signage outside the room to alert visitors and staff to see	F 880	It is the policy and procedure of the facility infection control plan to perform ongoing surveillance for infection prevention, identification and treatment. The infection preventionist is notified of all infections in the facility thru daily IDT meeting and thru the PCC 24-hour report	

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F 880	Continued From page 66 the nurse before entering the room for instructions for one (R124) of two residents sampled for transmission based precautions; indicate the date when the oxygen tubing was initially used for one (R58) of one resident; and follow infection control practices related to the storage of nebulizer equipment and oxygen tubing when not in use by one (R58) of one resident observed with nebulizer treatment and oxygen therapy in the sample of 49. Findings include: 1. Interview on 3/30/18 at 10:15am with the Infection Control Preventionist (ICP) identified the facility did not have a "Surveillance Plan." The ICP stated she was not familiar with the content of the "Facility Assessment" and did not know that the assessment should be used to determine the criteria for the facility surveillance plan. The ICP indicated she collects data on residents with infections and keeps a listing of the monthly percentage rate which is brought to the Quality Assurance Committee, but does not conduct surveillance rounds in the facility. ICP stated she started the position in late August 2017 and the former ICP provided an orientation, however, did not mention any requirement for conducting surveillance in the facility. The ICP indicated she monitors the facility infections and the percentage rates monthly. If needed education is provided to staff. In October 2017 the facility infection rate was 9.34% with 10 residents with Urinary Tract Infections (UTI) related to Escherichia coli (e-Coli) and education was provided to nurse aides on proper peritoneal care. The ICP could not provide documentation of follow up surveillance of staff to ensure compliance with the education.	F 880	system. Infection preventionist will randomly audit departments monthly to ensure proper infection control compliance. Facility QAPI will review audit results for compliance. The facility follows the McGreers and Loebs criteria for infections for surveillance purposes. Infection Preventionist performs routine environmental rounds and collects data for ongoing surveillance for determination of trends. The data is reviewed monthly and quarterly at the facility QAPI meeting. The infection prevention program is reviewed annually by an outside consulting firm. All staff have been trained in infection prevention and control per online Relias training. Courses include: infection control and prevention, Blood borne Pathogens, infection control essentials, perineal and catheter care. All residents with infections will be audited for the next 30 days to ensure proper interventions are followed with results reported to the facility QAPI. All nursing staff has been educated on 4/16/2018 to ensure all isolation rooms have a sign on the door for visitors and family to see the nurse prior to entering the room. All nursing staff was educated on 4/16/2018 on proper labeling of tubing. Reviewed and revised facility policy on Nebulizer treatments staff educated on 4/17/18. R58 is care plan for self-administration of nebulizer after set up. R58 was educated on importance of proper mask placement and infection prevention. Nurse aide task set up to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 880	Continued From page 67 Interview with the DON on 3/30/18 at 11am identified he makes rounds in the building to check for cleanliness but does not document the rounds, did not have specific criteria for what was being monitored and did not document outcomes or follow up. The rounds were not being done as infection control surveillance rounds. The DON further stated that a contractor comes in the facility once a year to conduct rounds. The contractor did not conduct facility specific infection control surveillance rounds. The DON indicated he was unaware that a formalized surveillance program was required. 2. Review of the "Physicians Orders" for R124's documented diagnosis to included enterocolitis due to clostridium difficile. The "Physician orders" for R124 dated 3/01/18 directed "C-Difficile precautions every shift." The care plan dated 3/01/18 identified R124 has "C-Difficile" with interventions that included "contact precautions, wear gowns and masks when changing contaminated linens." The admission "Minimum Data Set Assessment" (MDS), a comprehensive physical and psychosocial assessment, dated 3/14/18 identified a Brief Interview for Mental Status (BIM) of 13 (cognitively intact), extensive assistance of one person for toileting, frequent incontinence of bowel, and Enterocolitis due to C-Difficile, for R124. Observation on 3/27/18 at 8:30am identified a cabinet that included Personal Protective Equipment (PPE) outside R124's room. The room	F 880	monitor placement of mask when not in use on 4.17.18. Facility QAPI will review audit results for compliance. Director of Nursing is responsible for overall compliance. Completion date 4/26/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 880	Continued From page 68 did not have a sign posted on the door directing visitors to see the nurse prior to entering the room for education on hand washing. Interview with the Infection Control Preventionist (ICP) on 3/27/18 at 10am identified R124 was on "C-Difficile precautions" which required signage outside the room to alert visitors and staff to see the nurse before entering the room for instructions. The ICP could not explain why the sign was not posted. An undated "Facility Policy" related to "C-Difficile" directed staff to "use contact precautions for residents with known or suspected C-Difficile associated disease. Hang sign on door directing visitors to see the nurse prior to entering for education on hand washing..." 3. Observation of R58's room on 3/27/18 at 10:48am revealed that R58's nebulizer mask was sitting on top of his recliner's arm rest and R58's oxygen tubing was sitting on top of the oxygen tank. The nebulizer mask and oxygen tubing were not dated. Observation of R58 on 3/28/18 at 12:05pm revealed that LPN2 (Licensed Practical Nurse) administered nebulizer treatment to R58. After the treatment, LPN2 disconnected the nebulizer mask and tubing from the nebulizer machine and placed them on top of the over-bed table. During the same observation, R58's oxygen tubing was noted to be on the floor. LPN2 took R58 to the dining room for lunch after the procedure without aseptically (using methods to protect against infection by pathogenic microorganisms) storing the nebulizer mask, nebulizer tubing and oxygen tubing.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 69 Observation of R58's room on 3/29/18 at 8:41am revealed that R58's nebulizer mask and tubing were sitting on top of the over-bed table and the oxygen tubing was sitting on top of R58's bed. The oxygen tubing was not dated. In an interview with the Director of Nursing (DON) on 3/29/18 at 3:21pm, the DON stated that the placement of the nebulizer mask and tubing at the over-bed table was okay but also stated that the oxygen tubing should be kept off the floor. The DON further stated, "The oxygen tubing was supposed to be dated. I would like to see it dated but the TAR [treatment administration record] would give us the documentation [keeping track of when the oxygen tubing should be replaced]. It should be documented somewhere." In a concurrent observation and interview with LPN3 on 3/29/18 at 4:05pm, she verified that R58's oxygen tubing was not dated, had to be thrown away and replaced. LPN3 also stated, "If the oxygen tubing was not dated, we should change it right away and then date it. LPN3 further stated when asked about the oxygen tubing that was found on the floor, "It [oxygen tubing] should have been changed when seen on the floor." The surveyor asked LPN3 about the aftercare of nebulizer mask when finished with nebulizer treatment. LPN3 stated, "The nebulizer mask should be rinsed after use and put on top of paper towel upside down to dry in the washroom until the next use." Further interview with LPN3 on 3/29/18 at 4:19pm revealed when asked to show in the TAR or MAR	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 70	F 880		

(medication administration record) if there was a documentation of when the oxygen tubing was to be replaced, LPN3 stated, "I didn't see it [documentation that there was a date when oxygen tubing was scheduled to be changed] in there [MAR/TAR] and I would put it now."

Review of R58's TAR or MAR for the month of March 2018 revealed no documentation that the facility was keeping track of when the oxygen tubing should be replaced if the nursing staff failed to date the oxygen tubing. Further review of R58's MAR for the month of March 2018 revealed that the nebulizer mask and tubing was replaced on 3/14/18 and 3/28/18.

Review of R58's Medication Review Report for the month of March 2018 revealed an order to "Change neb [nebulizer] mask and tubing in the morning every 14 days for infection control." This was in conflict with the facility's policy related to the frequency of replacing the nebulizer mask and tubing.

Review of the facility's undated "Aerosol Nebulizer Therapy Without Positive Pressure" policy and procedure revealed under "Clean:" "1. Remove nebulizer from tubing. 2. Rinse unit with fresh tap water. 3. Air [dry] unit. 4. Store unit in basin with cloth cover, marked with resident's name and date between uses...6. New set required weekly."

Review of the facility's undated "Oxygen Administration" policy and procedure revealed under procedure, "...6. Masks and tubing are changed every 2 weeks or whenever they have become soiled..."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE** **FAIRMONT, MN 56031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0102 K6 PLAN APPROVAL: 1963, 1977, 1991 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: Building 0102 is a 1963 three (3) story, Type II (111) protected non-combustible construction with 1977 and 1991 additions of the same construction type and with a partial basement. The building has 16 smoke compartments and a complete automatic wet sprinkler system. Buildings 0102 and 0202 have a combined total of 17 smoke compartments. A Comparative Federal Monitoring Survey was conducted on 02/27/18, following a State Agency Annual Survey on 02/14/18 in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Lakeview Methodist Health Care Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 42 CFR 483.90(a) et seq. (Life Safety from Fire).	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control	K 324		2/27/18

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

Electronically Signed | 03/27/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE** **FAIRMONT, MN 56031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 1 and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain the kitchen hood filters. The deficient practice affected one (1) of 16 smoke compartments, staff and a limited number of residents. The facility has the capacity for 82 beds with a census of 71 on the day of survey. Findings include: Observation during the building inspection tour on 02/27/18 at 10:20 a.m. revealed a kitchen range hood filter was resting the opposite direction from the installation position on one side of the hood. When the filter was pushed back into place by	K 324	Grease Filters removed cleaned and installed on 2/27/2018. Clips were installed to help hold filters in place. Monthly cleaning and weekly inspections of filters to insure filters are in place. Director of building services responsible for monitoring and compliance. Date completed 2/27/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE** **FAIRMONT, MN 56031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 2 Maintenance Personnel, the filter on the opposite side became displaced. Interview with Maintenance Personnel on 02/27/18 at 10:20 a.m. confirmed the filters would not stay in place due to restricted air flow by clogged and/or dirty filters. Interview with the Maintenance Director on 02/27/18 at 10:20 a.m. revealed the facility was not aware how long the filter had been out of place, and the filters would be taken down and cleaned immediately to enable proper exhaust air flow. The census of 71 was verified by the Director of Nursing, on 02/27/18. The finding was acknowledged by the Foundation Director representing the Administrator, and verified by the Maintenance Director during the exit interview on 02/27/18. Actual NFPA Standard: 2012 Life Safety Code, NFPA 101, 19.3.2.5.1 Cooking facilities shall be protected in accordance with 9.2.3, unless otherwise permitted by 19.3.2.5.2, 19.3.2.5.3, or 19.3.2.5.4. NFPA 101, 9.2.3 Commercial cooking equipment shall be in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 96, 6.2.3.3 Grease filters shall be arranged so that all exhaust air passes through the grease filters. NFPA 96, 6.2.3.5 Grease filters shall be installed at an angle not less than 45 degrees from the horizontal.	K 324		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **02 - THE CHAPEL** B. WING _____	**02/27/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE** **FAIRMONT, MN 56031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0202 K6 PLAN APPROVAL: 2000 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: Building 0202 is a 2000 one (1) story, Type V (111) protected combustible wood frame construction with one (1) smoke compartment, and with complete automatic wet and dry sprinkler systems. Buildings 0102 and 0202 have a combined total of 17 smoke compartments. A Comparative Federal Monitoring Survey was conducted on 02/27/18, following a State Agency Annual Survey on 02/14/18 in accordance with 42 Code of Federal Regulations, Part 483: Requirements for Long Term Care Facilities. During this Comparative Federal Monitoring Survey, Lakeview Methodist Health Care Center was found to be in compliance with the Requirements for Participation in Medicare and Medicaid as set forth in Title 42, Code of Federal Regulations, 483.90 (a) et seq. (Life Safety from Fire).	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/27/2018

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.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WGW3

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00360

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245280**
2.STATE VENDOR OR MEDICAID NO.
(L2) **285042700**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKEVIEW METHODIST HEALTH CARE CENTER**
(L4) **610 SUMMIT DRIVE**
(L5) **FAIRMONT, MN** (L6) **56031**

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 **02/16/2018** (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 **82** (L18)
13.Total Certified Beds **82** (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
	82			
(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 :
Susan Kalis, HFE NE II 03/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Debby Baker, Enforcement Specialist 04/06/2018 (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
06/01/1985
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 2, 2018

Ms. Deborah Barnes, Administrator
Lakeview Methodist Health Care Center
610 Summit Drive
Fairmont, MN 56031

RE: Project Number S5280027

Dear Ms. Barnes:

On February 16, 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.

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 ellectronically delivered CMS-2567 whereby corrections are required.

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:

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

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 28, 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 March 28, 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 May 16, 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 August 16, 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.

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@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
	245280	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

(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 2/12/18 through 2/16/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On February 12,13, 14, 15, 16, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		3/15/18

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

Electronically Signed | 03/07/2018

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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F 688	Continued From page 1 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a splint was applied for 1 of 1 residents (R48) reviewed for range of motion (ROM). Findings include: R48's undated Admission Record face sheet, identified diagnoses of aphasia (loss of ability to understand or express speech), hemiplegia (paralysis of half your body) and hemiparesis (partial loss of movement) following cerebrovasular disease (stroke) affecting left non-dominant side. R48's quarterly Minimum Data Set (MDS) dated 12/13/17, indicated R48 required extensive assistance for bed mobility, transfers, and dressing. The MDS identified R48 with functional limitations to both upper and lower extremities and further identified R48 with physical therapy and occupational therapy minutes during the seven day look back. An occupational therapist (OT) progress and discharge summary dated 1/13/18, indicated a splint was fitted to R48's left hand and forearm in	F 688	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that the deficiency exists or that one was cited correctly. This Plan of correction is submitted to meet requirements established by State and Federal Law. It is policy of this facility to follow physician orders for mobility, PROM, and placement of brace. Staff education completed on 2/15/18, in regards to R48, to make sure all staff know mobility and range of motion needs along with brace placement. To enhance currently compliant operations under the direction of the Director of Nurses, facility wide all staff will receive in-service training regarding state and federal requirements for increasing/prevention of decrease ROM/Mobility on 3/15/2018. The training will emphasize the importance of range of motion exercises as indicated in care plan and following physician orders. For R48 on 2/15/18 and electronic medical record task was set up to preform PROM and apply splint to Left arm when in bed. Also	

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F 688	Continued From page 2 order to maintain ROM and decrease chances of contractures forming. The note further identified R48 would require staff assist to don resting hand splint and carry out wearing schedule in order to have maximum prevention from contractures. A therapy communication note dated 1/13/18, located in the nursing assistant rehabilitation book contained the following: perform passive range of motion (PROM) to R48's left hand prior to putting resting hand splint on in order to promote best fit. Please don resting hand splint to left hand when R48 is resting in bed during the day. Increase R48's wearing schedule to at night starting next week. Please let therapy know if R48 has any problems with fit of resting hand splint. A review of R48's physician orders dated 2/13/18 included an order for: left hand splint; PROM to left hand prior to putting resting hand splint on in order to promote best fit. Don resting hand splint to left hand whn R48 is resting in bed during the day. Increase wearing schedule to at night. Let therapy know if R48 has any problems with fit of resting hand splint. This same order followed through to R48's treatment administration record (TAR) each shift for the months of January and February 2018. During observation on 2/13/18, at 2:20 p.m. R48 was observed to be resting in bed. A left hand splint was observed on dresser in the room and not on R48's left hand. During further observations on 2/14/18, at 7:06 a.m. and 2/15/18 at 3:46 p.m., R48 was observed laying in bed without a splint on left hand.	F 688	for R48 nursing treatment was set up in the TAR to monitor Left hand splint and PROM to hand prior to putting on brace when resting in bed. This will be documented on the Nurse□s TAR. Audits will be done to ensure compliance and the findings of the audits will be addressed quarterly at the QAPI committee meeting for further review by the Director of Nursing and the Resident Care Coordinator. Auditing will continue unit it goes through the QAPI committee for review and acceptance. All staff education will be on 3/15/2018.	

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F 688	Continued From page 3	F 688		

During interview on 2/14/18, at 8:24 a.m. nursing assistant (NA)-A indicated R48 did not receive PROM or wear a splint during the day but was maybe a task completed during the evening. At 1:11 p.m. NA-B was interviewed and stated she was not aware of any splint schedule for R48 and had not ever observed R48 to wear one. NA-B then picked up the splint from the dresser and stated, "Honestly, it looks pretty new, maybe its something therapy is working on him with."

On 2/15/18, at 1:30 p.m. NA-C stated she was not aware of a splint schedule or PROM orders for R48.

Nursing progress notes were reviewed from 1/13/18 to 2/15/18. There was no documentation of R48 not wearing, refusing, or not tolerating the left hand splint.

During interview on 2/15/18, at 1:36 p.m. licensed practical nurse (LPN)-D stated the nursing assistants do PROM and apply left hand splint when R48 is in bed. LPN-D further verified there was no documentation from the nursing assistants doing this, however the nurse acknowledged the splint application on the treatment record as a completed task each shift.

During interview on 2/15/18, at 2:18 p.m. registered nurse (RN)-C verified the splint should be on when resting in bed or communication to therapy with refusal. RN-C further indicated all of the nursing assistants should know about the PROM and splint application as it is in their rehabilitation book that is to be followed with cares.

During interview on 2/16/18, at 8:36 a.m. the

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F 688	Continued From page 4 occupational therapist stated she would expect nursing to follow R48's PROM and left hand splint wearing schedule to prevent contractures. The occupational therapist evaluated R48's left hand and confirmed there had been no change to R48's left hand ROM at this time. On 2/16/18, at 10:10 a.m. the director of nursing (DON) confirmed the nursing department should complete R48's PROM and apply left hand splint as directed by therapy and verified his expectation is that staff would complete or notify therapy with any difficulties in procedure.	F 688		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced	F 692		3/15/18

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F 692	Continued From page 5 by: Based on observation, interview, and document reveiw, the facility failed to ensure a therapeutic diet was provided for 1 of 3 residents (R18) reviewed for nutrition. Findings include: R18's undated Admission Record face sheet, identified diagnosis of end stage renal disease with dependence on renal dialysis. R18's admission Minimum Data Set (MDS) dated 11/14/17, identified R18 as requiring supervision and set-up with eating, on a therapeutic diet, and receiving dialysis. R18's physician orders dated 2/13/18, included order for Renal diet, regular texture regular consistency. R18's care plan last revised 2/6/18 included: provide, serve diet as ordered (renal dialysis). On 2/14/18, at 8:37 a.m. R18 was observed to be eating breakfast in her room. R18's breakfast consisted of a hard boiled egg, toast with jelly, a whole banana and glass of orange juice. R18 stated she isn't suppose to have orange juice or bananas but indicated quite often she has orange juice and bananas served to her. During interview on 2/14/18, at 12:29 p.m. dietary director stated extension sheets are utilized for renal diets. Upon review of the extension sheet, it identified any juice except orange juice and any fruit except bananas or oranges as acceptable for renal dialysis residents.	F 692	It is policy of this facility to follow physician orders regarding resident diets. Staff education completed on 2/19/18 to make sure all dietary staff know how to read and follow each resident□s diet. Dietary Director will educate dietary staff on 3/7/18 on new policy of resident color coated dietary cards to simplify process for all residents in the facility. For resident R18 staff educated on foods and drinks that have high potassium levels. To enhance currently compliant operations under the direction of the Dietary Director, all staff will receive in-service training regarding state and federal requirements following resident diets 3/15/2018. The training will emphasize the importance of following diets as indicated in care plan and which foods residents need to avoid for a low potassium diet along with new dietary cards. Audits will be done to ensure compliance and the findings of the audits will be addressed quarterly at the QAPI committee meeting for further review by the Dietary Director. Auditing will continue unit it goes through the QAPI committee for review and acceptance. All staff education will be on 3/15/2018.	

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F 692	Continued From page 6 On 2/15/18, at 8:25 a.m. R18 requested a breakfast tray from nursing. When the tray was delivered to R18 it included a banana. R18 pointed to the banana and stated "I can't have that". Observation of R18's breakfast table in the dining room at 8:32 a.m. included a placemat and dietary card. R18's dietary placement card indicated "no oj" in red marker, however, a glass of orange juice was sitting at R18's spot at the table. On 2/15/18, at 1:11 p.m. dietary aide (DA)-A confirmed orange juice had been placed for R18 to drink for breakfast, and verified R18 should not have orange juice per her dietary card and orders. At this time, the dietary manager confirmed R18 should not receive orange juice or bananas on a renal diet, stating, "It was an error and we need to fix it." The dietary manager further indicated a better system was needed for dietary staff to follow related to therapeutic diets. The facility policy titled Prescribed Diet Policy revised 5/1/15, included: Therapeutic menus are planned in writing, and prepared and served as ordered with supervision or consultation from dietician and advice from the physician whenever necessary. Renal diets will be provided, which will be monitored by the L.D. (licensed dietician).	F 692		
F 880 SS=F	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.	F 880		3/15/18

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F 880	Continued From page 7 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(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	F 880		

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F 880	Continued From page 8 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed 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 implement a program to reduce the risk of a Legionnella (a bacterium) in the facility water system to prevent cases and outbreaks of Legionnaires' disease (a serious type of respiratory illness). This had the potential to affect all 77 residents who resided in the facility. Findings include: During a phone interview on 2/21/18 at 8:43 a.m., the director of building services (DBS) verified he was responsible for the development of facility policies pertaining to water born illness. The DBS stated the facility had not completed a risk assessment which identified where Legionella and other opportunistic waterborne pathogens (e.g. Pseudomonas, Acinetobacter, Burkholderia, Stenotrophomonas, nontuberculous	F 880	Lakeview Methodist Building Services Manager has reviewed the CDC toolkit in detail, and has contracted with Minnesota Testing Labs technician to be a member of our Water Management Team, which also will include our chemical supplier and a consultant from our city water treatment plant. 3-9-18 BSM has described the Building Water Systems in both narrative and diagram form on 3-1-18, and continues to log weekly water testing for chlorine and PH levels which began on 11-22-17. By 3-15-18 DSM and his staff will have identified areas where Legionella could grow and spread doing a second risk analysis with input from team members. First risk analysis completed in June,	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9 mycobacteria, and fungi) could grow and spread in the facility water system and was unable to provide a risk assessment. The DBS confirmed the facility had not developed a facility specific policy and procedure. A policy presented at the time of survey and identified as the facility policy, Legionnaires Disease and Water Management Program, issued August 2017, indicated Legionella infections can cause a serious type of pneumonia (Legionnaire's Disease) in persons at risk, and that outbreaks have been linked to poorly maintained water system in building with large or complex water systems, including hospitals and long-term care facilities. The policy indicated the Water Management Program included key elements: All Good Samaritan Society rehab/skilled locations will identify a water management team at their location that will annually, and with any major maintenance and water service change, identify where legionella could grow(Lakeview Methodist is not a Good Samaritan Society owned facility). This team, supported by an external vendor with expertise in water management programs, will determine the water management program for the location. - conducting a risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread; - implementing a water management program including control measures, inspections and environmental testing for pathogens; and - testing protocols, acceptable ranges of control measures, documentation of results and corrective actions taken when control limits are not maintained. The policy indicated important facets of infection	F 880	2017, caused Lakeview to turn off water to decorative outdoor fountain. Control measures, monitoring of control measures, and interventions when not met will be established and written with input from team members. 3-9-18 At all staff meeting on 3-15-18 DON will review signs and symptoms of Legionnaires□ disease and accompanying nursing protocols. Legionnaires□ Disease Lakeview Specific Policy will be reviewed to include all areas specified from CDC and will be presented to all staff on 3-15-18.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING _____ B. WING _____	02/16/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	610 SUMMIT DRIVE FAIRMONT, MN 56031

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F 880	Continued From page 10 prevention included, "following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC)." When interviewed on 2/21/18, the DBS verified the facility had not completed a full risk assessment, or analyzed the building's water supply. The DBS expressed not being aware of having to conduct a risk assessment for the facility. The DBS was also not aware of a policy titled Legionnaire's Disease and Water Management program for the facility.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE** **FAIRMONT, MN 56031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOU 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 RECEIPTS 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, Building 01 of Lakeview Methodist Health Care Center was found not to be 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 Occupancies. Lakeview Methodist Health Care Center was constructed as follows: Building 01 consists of the 1963, 1978 and 1993 buildings. Building 01 is three stories in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; Building 02 represents the 2000 addition, and consists of a chapel, main entrance, business offices, mechanical room and a link to an assisted living facility. This addition is one-story	K 000	EPOC	

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

Electronically Signed | 03/07/2018

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2018**

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K 000	Continued From page 1 in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. 2-hour fire wall assemblies separate both the buildings of Type II(111) construction from the addition of Type V(111) construction, and, the nursing home from an assisted living facility. Opening protectives consist of labeled, self-closing, positive latching, 90-minute fire door assemblies. In accordance with NFPA 101 (2012) Chapter 19, Table 19.1.6.2, a three-story building of Type V(111) construction is not permitted. As such, the facility was surveyed as two-buildings, and two Form CMS-2786R booklets were completed. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 85 beds and had a census of 76 at time of the survey.	K 000		
K 211 SS=F	The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1	K 211		3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2018**

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LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE FAIRMONT, MN 56031**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 211	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to be in accordance with Chapter 7, which states, all means of egress is to be continuously maintained free of all obstructions to full use in case of emergency. This deficient practice could affect 76 of the 76 residents. Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 02/14/2018, observation revealed an exit door from the Fellowship Hall was observed blocked with a table. This deficient practice was verified by the Facility Maintenance Director.	K 211	Educated daycare staff on keeping area in front of Emergency exits unobstructed. Sign was placed by fellowship exit stating keep door clear of tables and chairs. Director of building services responsible for monitoring and compliance. Date completed 2-16-18.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or	K 923		3/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/14/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW METHODIST HEALTH CARE CENTER	**610 SUMMIT DRIVE** **FAIRMONT, MN 56031**

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K 923	Continued From page 3 within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 5.1.3.3.2 (NFPA 99). This deficient practice could effect 76 of 76 residents. Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and	K 923	All oxygen cylinders were removed from B-1 and securely placed in oxygen room 235 on 235 on 2nd floor. Director of building services responsible for monitoring and compliance date completed 2-15-2018	

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K 923	Continued From page 4 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99). This deficient practice could effect 106 of the 106 residents. FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM	K 923		

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K 923	Continued From page 5 on 02/14/2018, observation revealed that in the lower storage room (B-1) 5 oxygen cylinders were observed being stored within this room. The door into this room was not labeled indicating gas storage was occurring within this area. This deficient practice was verified by the Facility Maintenance Director.	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. BUILDING **02 - THE CHAPEL** B. WING _____	**02/14/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Building 02 of Lakeview Methodist Health Care Center was found not to be 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 Occupancies. Lakeview Methodist Health Care Center was constructed as follows: Building 01 consists of the 1963, 1978 and 1993 buildings. Building 01 is three stories in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; Building 02 represents the 2000 addition, and consists of a chapel, main entrance, business offices, mechanical room and a link to an assisted living facility. This addition is one-story in height, has a partial basement, is fully fire sprinkler protected and was determined to be of Type V(111) construction. 2-hour fire wall assemblies separate both the buildings of Type II(111) construction from the addition of Type V(111) construction, and, the nursing home from an assisted living facility. Opening protectives consist of labeled, self-closing, positive latching, 90-minute fire door assemblies.	K 000	EPOC	

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

Electronically Signed | 03/07/2018

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K 000	Continued From page 1 In accordance with NFPA 101 (2012) Chapter 19, Table 19.1.6.2, a three-story building of Type V(111) construction is not permitted. As such, the facility was surveyed as two-buildings, and two Form CMS-2786R booklets were completed. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of beds and had a census of 76 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be	K 923		3/7/18

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K 923	Continued From page 2 stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to comply with 5.1.3.3.2 (NFPA 99). This deficient practice could effect 76 of 76 residents. Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual	K 923	Both Oxygen cylinders placed in carts to secure. Will monitor oxygen room daily for unsecured cylinders. Director of Building Services responsible for monitoring and compliance. Date completed 2-15-2018. Letters to all hospice providers were educated on proper securing of oxygen tanks in accordance with our policy on 3/7/2018.	

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K 923	Continued From page 3 cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99). This deficient practice could effect 106 of the 106 residents. FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 02/14/2018, 2 oxygen cylinders were observed being stored within the 2nd floor Oxygen Storage Room (23-S) unsecured or chained to prevent them from falling . This deficient practice was verified by the Facility Maintenance Director.	K 923		