DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 6, 2022

Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, MN 55063

RE: CCN: 245374
Cycle Start Date: November 22, 2021

Dear Administrator:

On December 8, 2021, we notified you a remedy was imposed. On December 21, 2021 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 17, 2021.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 23, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of December 8, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 23, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 17, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

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

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 6, 2022

Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, MN 55063

Re: Reinspection Results
Event ID: CPMB12

Dear Administrator:

On December 21, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 21, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically Submitted
December 8, 2021

Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, MN 55063

RE: CCN: 245374
Cycle Start Date: November 22, 2021

Dear Administrator:

On November 22, 2021, survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

REMOVAL OF IMMEDIATE JEOPARDY

On November 22, 2021, the situation of immediate jeopardy to potential health and safety cited at E0020 was removed. However, continued non-compliance remains at the lower scope and severity of F.

Also on November 19, 2021, the situation of immediate jeopardy to potential health and safety cited at K 781 was removed.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 23, 2021.

This Department is also recommending that CMS impose a civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 23, 2021, (42 CFR 488.417 (b)), (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 23, 2021, (42 CFR 488.417 (b)).

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective November 22, 2021. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

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

DEPARTMENT CONTACT

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE 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 May 22, 2022 (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.

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

APPEAL RIGHTS DENIAL OF PAYMENT

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you

have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

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

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	C 11/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 11/19/21, through 11/22/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The survey resulted in an immediate jeopardy (IJ) to resident health and safety. An IJ at E0020 began on 10/29/21, when the facility started the use of space heaters to heat resident rooms, and the facility did not have an evacuation plan in the event residents would require an emergency evacuation. The administrator, director of nursing (DON), social services designee (SS)-D, and chief financial officer (CFO) were informed of the IJ on 11/19/21, at 5:27 p.m. The IJ was removed on 11/22/21, at 2:50 p.m. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 020 SS=L	Policies for Evac. and Primary/Alt. Comm. CFR(s): 483.73(b)(3) §403.748(b)(3), §416.54(b)(2), §418.113(b)(6)(ii), §441.184(b)(3), §460.84(b)(3), §482.15(b)(3), §483.73(b)(3), §483.475(b)(3), §485.68(b)(1), §485.625(b)(3), §485.727(b)(1), §485.920(b)(2), §491.12(b)(1), §494.62(b)(2)	E 020		11/22/21

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

Electronically Signed | 12/15/2021

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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E 020	Continued From page 1 [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least every 2 years [annually for LTC facilities]. At a minimum, the policies and procedures must address the following:] [(3) or (1), (2), (6)] Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. *[For RNHCIs at §403.748(b)(3) and ASCs at §416.54(b)(2):] Safe evacuation from the [RNHCI or ASC] which includes the following: (i) Consideration of care needs of evacuees. (ii) Staff responsibilities. (iii) Transportation. (iv) Identification of evacuation location(s). (v) Primary and alternate means of communication with external sources of assistance. * [For CORFs at §485.68(b)(1), Clinics, Rehabilitation Agencies, OPT/Speech at §485.727(b)(1), and ESRD Facilities at §494.62(b)(2):] Safe evacuation from the [CORF; Clinics,	E 020		

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E 020	Continued From page 2 Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services; and ESRD Facilities], which includes staff responsibilities, and needs of the patients. * [For RHCs/FQHCs at §491.12(b)(1):] Safe evacuation from the RHC/FQHC, which includes appropriate placement of exit signs; staff responsibilities and needs of the patients. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the development of an emergency preparedness (EP) plan to address the safe evacuation of residents from the facility in the event of an emergency. This resulted in an immediate jeopardy (IJ) to all 24 residents residing at the facility. The IJ began on 10/29/21, when the facility allowed space heaters in resident rooms to provide heat after the facility boiler stopped working. On 11/19/21, the facility's north natural gas meter was shut off by the natural gas company due to multiple gas leaks. The facility EP lacked a comprehensive evacuation plan in the event all residents had to be evacuated from the facility in an emergency situation. The administrator, director of nursing (DON), social services designee (SS)-A, and chief financial officer (CFO) were informed of the IJ on 11/19/21, at 5:27 p.m. The IJ was removed on 11/22/21, at 2:50 p.m., however, scope and severity remained at an F, widespread, no actual harm with potential for more than minimal harm. Findings include:	E 020	E020 The emergency preparedness evacuation plan was reviewed and updated to include a community location at Journey North Church. The Emergency Operations Plan now includes this location and contacts, as well as potential transportation options. All residents have a potential to be effected by this citation but no harm has occurred due to this citation. All staff were educated on 11/22/21 on the approved EOP evacuation plan. The administrator, DON or designee is responsible for the EOP. The facility will review the EOP quarterly at the QAPI meeting.	

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E 020	Continued From page 3 On 11/19/21, at 9:53 a.m. the North boiler room located on the lower level was observed with the fire marshal (FM)-A. In the boiler room, four boilers were not functioning. An odor of natural gas was detected, and FM-A contacted the local fire department. On 11/19/21, at 10:51 a.m. the administrator was interviewed and stated she was unsure exactly where residents would go in the event they needed to evacuate the building. The administrator stated they would contact their healthcare coalition or the National Guard to assist in the event residents had to be evacuated. The administrator stated she was unaware of a location where residents would be evacuated to, and if the facility would send supporting documents. On 11/19/21, at 11:48 a.m. the administrator was interviewed and provided documentation of an estimate from a construction company for new boilers dated 3/22/21. The administrator stated the North boilers were turned off for the season approximately May of 2021. The administrator provided a hand written timeline which indicated the North boiler failed to work on 10/15/21, when they facility attempted to turn it on. The administrator stated the facility started the use of space heaters to keep residents warm on 10/29/21. The administrator also provided a receipt from a local store indicating five space heaters were purchased on 11/3/21, at 1:53 p.m to be placed in resident rooms and common areas to provide heat. On 11/19/21, at 12:10 p.m. the facility EP plan was reviewed. The facility emergency evacuation	E 020		

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E 020	Continued From page 4	E 020		

policy failed to identified how residents would be safely evacuated in the case of an emergency, including a location where they would be evacuated to.

On 11/19/21, at 12:28 p.m. FM-A was interviewed and stated he spoke with the facility maintenance (M)-A. FM-A stated M-A stated he only worked at the facility part time and did minor maintenance on small things such as lighting; he did not manage the boilers at the facility. FM-A stated the fire department found natural gas leaks and notified the natural gas company to come to the facility and conduct an inspection.

On 11/19/21, at 1:05 p.m. the natural gas employee (NGE)-A and FM-A were interviewed. NGE-A stated there were concerns that the newly installed furnaces were not functioning properly because they were not installed properly. NGE-A stated multiple gas leaks were found in the boiler room, and for those reasons the north gas meter would need to be turned off until the furnace installation and gas leaks were repaired. FM-A stated he was unable to find required permits for the installation of the new furnaces with the state or county.

On 11/19/21, at 3:55 p.m. the administrator verified the facility did not have a safe evacuation plan in the event of an emergency evacuation.

The facility Emergency Operations Plan, revised 9/14/20, lacked identification of a safe evacuation plan in the event of an emergency evacuation.

The immediate jeopardy that began on 10/29/21, was removed on 11/22/21, when the facility developed an emergency evacuation plan that

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E 020	Continued From page 5 included a location to send residents in case of an emergency evacuation, and transportation to the location was identified. The facility also educated all staff on the emergency evacuation plan. This was verified through interview and document review.	E 020		
F 000	INITIAL COMMENTS On 11/19/21, through 11/22/21, a standard abbreviated survey was completed at your facility by surveyors from the Minnesota Department of Health (MDH). The facility was NOT found not to be in compliance with requirements of 42 CFR Part 483, Subpart B, the requirements for Long Term Care Facilities. At the time of the abbreviated survey, onsite investigations were completed and the following complaint was found to be substantiated : H5374026C (MN78582, MN78057) with deficiencies cited at F584, F712, F714, F715, F841, and F846. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7)	F 584		12/14/21

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 584	Continued From page 6 §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	C 11/22/2021

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

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F 584	Continued From page 7 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe and comfortable room temperature for 18 of 24 residents (R1, R2, R7, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, and R23) who resided on the North wing and reviewed for temperature concerns. Findings include: On 11/19/21, at 9:12 a.m. the north hallway was observed with the fire marshal (FM)-A. Resident rooms were observed and space heaters were found in 10 resident rooms. Low wall heaters in resident rooms were cold to the touch. The hallway, dayrooms, and resident rooms felt cold. Residents were observed in both their rooms and dayroom wearing heavy clothing and blankets over their laps. Intake and output vents were noted to have no air flow or heat output. The majority of the vents were closed off in the hallway, dayrooms, and resident rooms. On 11/19/21, at 9:53 a.m. the north boiler room was observed with FM-A. There were four gas furnaces which were not operating. FM-A stated they appeared to be in "locked-out" indicating the furnaces shut themselves down after detecting a problem with how the furnace was functioning. On 11/19/21, from 10:54 a.m. until 11:17 a.m. room temperature readings on the North wing were observed with the director of nursing (DON). The DON stated she didn't know the date the facility became cold and they started using space	F 584	F584 Policy was developed to address comfortable room temperatures to remain between 71 and 81 degrees Fahrenheit. Residents affected by this citation where relocated to CD unit were temperatures are controlled by functioning boiler system. Outside of auditing, when a resident reports an uncomfortable room temperature, the room temperature will be checked. The facility will attempt interventions to get temperature into range and if unable due to achieve comfortable temperatures due to current weather conditions, an alternative room will be encouraged for room temps less than or greater than 5 degrees, and will be mandated for temperatures 10 degrees or more out of range. All residents have a potential to be effected by this citation but no harm has occurred due to this citation. Resident rooms will be audited for temperature compliance on all current resident rooms x 1 week, then 5 rooms x 3 weeks then 5 rooms monthly and then 5 rooms quarterly or until 100% compliance is achieved. The DON, administer or designee will be responsible for compliance. Audits will	

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F 584	Continued From page 8	F 584		

heaters, as some residents brought in their own. The DON recorded the following temperatures in occupied resident rooms on the North wing:

10:54 a.m. room 233, 58.2 degrees Fahrenheit (F).
10:57 a.m. room 226, 64.5 degrees F.
10:57 a.m. room 225, 62.3 degrees F.
10:59 a.m. room 223, 66.6 degrees F.
11:00 a.m. room 235, 66.3 degrees F.
11:01 a.m. room 236, 62.7 degrees F.
11:07 a.m. room 221, 65.1 degrees F.
11:09 a.m. room 201, 66.2 degrees F.
11:10 a.m. room 215, 70.7 degrees F.
11:10 a.m. room 202, 70.7 degrees F.
11:11 a.m. room 214, 68.4 degrees F.
11:13 a.m. room 204, 67.9 degrees F.
11:16 a.m. room 205, 68.2 degrees F.
11:17 a.m. room 206, 68.4 degrees F.

On 11/19/21, at 10:40 a.m. R2 was interviewed and stated the heating was "horse *." R2 stated his room heater was never on or working. R2 stated the only way he could keep his room warm was with the use of a space heater. R2 stated his bathroom was very cold. R2 stated he told the staff "constantly" about the cold temperatures, and the facility told him a new boiler had been installed. R2 stated he had not noticed a difference in his room temperature, it was still cold. R2 was observed wearing a heavy blanket over his legs.

On 11/19/21, at 10:47 a.m. R14 was interviewed. R14 stated his bathroom got very cold. R14 stated the heating in his room really didn't work, and he did not have any heat source.

On 11/19/21, at 10:51 a.m. the administrator was

be reviewed at QAPI meetings.

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F 584	Continued From page 9	F 584		

interviewed and stated she was not sure how long the heat had been off. The administrator stated the facility had ordered eight new boilers; four had already arrived and were installed. The administrator stated they were still waiting for the other four boilers to arrive for installation.

On 11/19/21, at 11:48 a.m. the administrator stated she was "pretty sure" the furnaces were turned off in May of 2021 and functioning at that time. The administrator stated on 3/22/21, the facility obtained an estimate from a company to install the new furnaces. The administrator stated the company notified the facility in July of 2021 they didn't have enough staff to install the equipment. The administrator stated the facility then contacted a different company who ordered the new boilers and agreed to perform the installation. The administrator stated on 11/9/21, the four installed furnaces were operational after a delay in needed parts and installation. The administrator provided an invoice from the company dated 10/26/21, indicating services provided, "Labor and Materials at Lakeside Medical Boiler Room North." The administrator stated they started using space heaters on 10/29/21, and also purchased five additional space heaters from a store on 11/3/21, for use in the facility until the furnaces were functional.

On 11/19/21, at 12:40 p.m. R1 was interviewed and stated the facility was very cold. R1 stated the heat hadn't worked for a long time, he wasn't sure, but believed it may have stopped working as far back as the past winter. R1 stated the space heater made his room warmer, but it was still was too cold for him. R1 stated he used multiple blankets to keep himself warm in his bed.

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F 584	Continued From page 10 On 11/19/21, at 1:05 p.m. the administrator was interviewed with natural gas employee (NGE)-A and FM-A present. NGE-A stated the new furnaces were not functioning properly due to being installed incorrectly. NGE-A stated the furnaces shut down on their own due to the incorrect installation. The administrator stated she was not aware the furnaces were not functioning. A policy addressing comfortable room temperatures was requested, but not provided.	F 584		
F 712 SS=C	Physician Visits-Frequency/Timeliness/Alt NPP CFR(s): 483.30(c)(1)-(4) §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 712	F712	12/10/21

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F 712	Continued From page 11 facility failed to provide a current policy addressing addressing physician visits and requirements for residents to seen every 30 days for the first 90 days, and every 60 days thereafter. This had the potential to effect all 24 residents residing at the facility. Findings include: On 11/22/21, at 11:13 a.m, facility policies were reviewed. The facility Protocol for Regulatory Nursing Home Visits policy was not dated or signed. The policy addressed manditory provider visits which a physican group, however, the facility was no longer contracted with that group. On 11/22/21, at 11:50 a.m. the administrator was interviewed and stated she unsure why the policy was not signed or dated.	F 712	The facility did not have facility policy addressing F712/ 483.30(c)(1)-(4) Physician Visits- Frequency/ Timeliness. The facility did however, have the regulation printed and was currently following the regulation. The DON has an Excel spreadsheet in which the regulatory visits are recorded and monitored for compliance. The DON provided a list of the required residents that were due to be seen each month per the regulations to the NP. Progress notes that serve as record of each visit are placed into the resident permanent record. A policy was developed to address this citation. This citation has the potential to affect all residents, but no residents were affected by this citation. DON, administrator or designee is responsible for keeping this policy up to date.	
F 714 SS=C	Physician Delegation of Tasks to NPP CFR(s): 483.30(e)(1)(4)(f) §483.30(e) Physician delegation of tasks in SNFs. §483.30(e)(1) Except as specified in paragraph (e)(4) of this section, a physician may delegate tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who- (i) Meets the applicable definition in §491.2 of this chapter or, in the case of a clinical nurse specialist, is licensed as such by the State; (ii) Is acting within the scope of practice as	F 714		12/14/21

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F 714	Continued From page 12 defined by State law; and (iii) Is under the supervision of the physician. §483.30(e)(4) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under State law or by the facility's own policies. §483.30(f) Performance of physician tasks in NFs. At the option of State, any required physician task in a NF (including tasks which the regulations specify must be performed personally by the physician) may also be satisfied when performed by a nurse practitioner, clinical nurse specialist, or physician assistant who is not an employee of the facility but who is working in collaboration with a physician. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a policy and procedure for physician delegation of tasks for disciplines working under the physician's supervision. This had the potential to affect all 24 residents residing at the facility. Findings include: On 11/22/21, at 11:13 a.m, facility policies were reviewed. The policies lacked a procedure for physician delegation of tasks. On 11/22/21, at 11:50 a.m. the administrator was interviewed and stated she was unable to locate a policy or procedure addressing physician delegation of tasks. The administrator stated she was not able to locate the policy and procedure,	F 714	F714 The facility did not have a facility policy addressing F714/ 483.30 (e)(1)(4)(f) Physician Delegation of Tasks. A policy was developed to address this citation. This citation has the potential to affect all residents, but no residents were harmed by this citation. DON, administrator or designee is responsible for keeping this policy up to date. Completion date 12/14/21.	

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F 714	Continued From page 13 and she was not sure if the facility had this policy and procedure.	F 714		
F 715 SS=C	Physician Delegation to Dietitian/Therapist CFR(s): 483.30(e)(2)(3) §483.30(e)(2) A resident's attending physician may delegate the task of writing dietary orders, consistent with §483.60, to a qualified dietitian or other clinically qualified nutrition professional who- (i) Is acting within the scope of practice as defined by State law; and (ii) Is under the supervision of the physician. §483.30(e)(3) A resident's attending physician may delegate the task of writing therapy orders, consistent with §483.65, to a qualified therapist who- (i) Is acting within the scope of practice as defined by State law; and (ii) Is under the supervision of the physician. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a policy and procedure for physician delegation to a dietitian. This had the potential to affect all 24 residents residing at the facility. Findings include: On 11/22/21, at 11:50 a.m. facility policies were reviewed. The policies lacked a procedure for physician delegation to a dietician. On 11/22/21, at 11:50 a.m. the administrator was interviewed and stated she was unable to locate a policy or procedure addressing physician	F 715	F715 The facility did not have a facility policy addressing F715/ 483.30 (e)(2)(3) Physician Delegation to Dietitian/ Therapist. A policy was developed to address this citation. This citation has the potential to affect all residents, but no residents were harmed by this citation. DON, administrator or designee is	12/14/21

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F 715	Continued From page 14 delegation to a dietitian. The administrator stated she could not locate the policy and procedure, and she was unsure if they had this policy.	F 715	responsible for keeping this policy up to date.	
F 841 SS=C	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a policy and procedure defining the responsibilities of the Medical Director. This had the potential to affect all 24 residents residing at the facility. Findings include: On 11/22/21, at 11:13 a.m, facility policies were reviewed. The policies lacked a procedure for responsibilities of the Medical Director. On 11/22/21, at 11:50 a.m. the administrator was interviewed and stated she was unable to locate a policy or procedure addressing The responsibilities of the Medical Director. The administrator stated she could not locate the policy and procedure, and she was unsure if they had this policy.	F 841	F841 The facility did not have a facility policy addressing F841/ 483.70 (h)(1)(2) Responsibilities of the Medical Director. A policy was developed to address this citation. This citation has the potential to affect all residents, but no residents were harmed by this citation. DON, administrator or designee is responsible for keeping this policy up to date.	12/14/21
F 846 SS=C	Facility Closure CFR(s): 483.70(m)	F 846		12/14/21

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F 846	Continued From page 15 §483.70(m) Facility closure. The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure, as required at paragraph (l) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a policy and procedure addressing facility closure. This had the potential to affect all 24 residents residing at the facility. Findings include: On 11/22/21, at 11:13 a.m. facility policies were reviewed. The policies lacked a procedure addressing facility closure. On 11/22/21, at 11:50 a.m. the administrator was interviewed and stated she was unable to locate a policy or procedure addressing facility closure. The administrator stated she could not locate the policy and procedure, and she was unsure if they had this policy.	F 846	F846 The facility did not have a facility policy addressing F846/ 483.70 (m) Facility Closure. A policy was developed to address this citation. This citation has the potential to affect all residents, but no residents were harmed by this citation. DON, administrator or designee is responsible for keeping this policy up to date.	

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	245374	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2021**

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K 000	INITIAL COMMENTS FIRE SAFETY A life safety complaint investigation was conducted by the State Fire Marshal Division on 11/19/2021. At the time of this complaint, Lakeside Medical Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. The immediate jeopardy began on 10/29/2021 when portable space heaters were purchased and placed in resident sleeping rooms and an egress corridor and was identified on 11/19/2021. The Administrator was notified of the immediate jeopardy at approximately 5:27 PM on 11/19/2021. The immediate jeopardy for K781 was removed on 11/19/2021 at 5:45 PM. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/14/2021

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

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K 000	Continued From page 1 PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Lakeside Medical Center is a 1-story building with a full basement. The original building was constructed in 1966, with an addition built in	K 000		

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

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K 000	Continued From page 2 1971. The 1966 and the 1971 buildings were both determined to be built of Type II(111) construction. The facility is fully protected throughout by an automatic fire sprinkler system. In addition, the facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility is divided into seven separate smoke compartments. The facility has a licensed capacity of 46 beds and had a census of 24 at the time of the investigation. The requirement at 42 CFR, Subpart 483.70(a), is NOT MET as evidenced by:	K 000		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install heating equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.5.2.1 and 9.1.1, NFPA 54 (2012 edition), National Fuel Gas Code, section 8.1.1.1. This deficient finding could have a widespread	K 521	K 521 The facility identified the AB boiler system was not functioning to maintain resident room temperatures on the AB units at a comfortable temperature. On 11/19/21, all	12/17/21

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	245374	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/19/2021**

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K 521	Continued From page 3 impact on the residents within the facility. Findings include: On 11/19/2021 at 0957, an observation revealed that when entering the boiler room with the four newly installed water heaters, all four water heaters were in a safety lockout mode triggered by the "Safgard" box. A strong smell of gas odorant was present in the room at the time of discovery. The fire department was called to use a gas meter to verify a natural gas leak. The fire chief decided to call the gas utility since his meters were not detecting gas, but he could also smell the presence of gas. Minnesota Energy Resources sent two technicians to the site, determined several gas leaks on the new water heaters, and decided to pull the gas meter and safety tag the system until repairs could be made. The health surveyor verified the new water heater installed through an interview.	K 521	residents were relocated from AB units to CD units. This provided all residents with a functional, safe heat source. This citation has the potential to affect all residents. No residents were harmed due to this citation. The facility currently has kept all residents on the CD units. AB units remain uninhabited by residents. The facility is waiting for parts and the contractors to complete their contracted work on the 8 boilers of A & B units. Following completion of work, the proper authorities will be contacted to inspect the system for regulatory functioning. Residents will then be offered rooms on the other units as appropriate. The facility will monitor for heat loss through resident concerns at care conferences, resident council, and via complaints. Room temps will be monitored via observational audits conducted in all resident rooms 2x for one week, weekly for 4 weeks, then monthly x3 months and quarterly thereafter; or until 100% compliance is achieved. Administrator, DON or designee are responsible for compliance and these audits will be reviewed at the QAPI meetings.	
K 781 SS=K	Portable Space Heaters CFR(s): NFPA 101	K 781		11/22/21

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K 781	Continued From page 4 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to prohibit the use of portable electric space heaters in resident rooms per NFPA 101 (2012 edition), Life Safety Code, section 19.7.8, when the temperature dropped due to a replacement of the boilers; portable space heaters were used in resident rooms and egress corridors to supplement heat, resulting in immediate jeopardy of injury or death in the event of a fire incident to 10 out of 24 residents. The immediate jeopardy began on 10/29/2021 when portable space heaters were purchased and placed in resident sleeping rooms and an egress corridor and was identified on 11/19/2021. The Administrator was notified of the immediate jeopardy at approximately 5:27 PM on 11/19/2021. The immediate jeopardy was removed, and the deficient practice was corrected on 11/19/2021. Findings include: The State Fire Marshal Division entered the facility with a Minnesota Department of Health investigator at 9:00 AM on 11/19/2021 to investigate the complaint of space heaters in use. On 11/19/2021 at 9:12 AM, observation revealed	K 781	Immediate plan of correction for K781, use of space heaters. All space heaters were removed from resident rooms and placed in staff offices on 11/19/21 for family pick up of personal heaters. Facility owned space heaters were taken off the floor. Families were called to pick up space heaters of residents at next convenient date on 11/20/21. Staff were notified verbally & in writing on 11/20/2021 that space heaters are no longer allowed under any circumstances. Sign in sheet for education placed upon start of next shift as proof of education. 7 of 24 residents had space heaters in room and were at risk to be affected by this citation. No actual harm has occurred due to this citation. The facility developed/ updated policies to educate family/ resident regarding prohibited use of space heaters. Training Plan	

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K 781	Continued From page 5 a portable electric space heater was found plugged in and turned on in the 238 Dayroom, which was open to the egress corridor and adjacent to a resident sleeping area. On 11/19/2021 at 9:13 AM, observation revealed a portable infrared space heater was found plugged in and turned on in resident room 235. On 11/19/2021 at 9:15 AM, observation revealed a portable electric space heater was found plugged in and turned on in resident room 224. The space heater was placed directly next to a curtain and liquid oxygen reservoir. On 11/19/2021 at 9:18 AM, observation revealed a portable electric space heater was found unplugged and not in use in resident room 225. On 11/19/2021 at 9:21 AM, observation revealed a portable electric space heater was found plugged in and turned on in resident room 226. On 11/19/2021 at 9:30 AM, observation revealed a portable electric space heater was found plugged in and turned on in resident room 222. On 11/19/2021 at 9:36 AM, observation revealed a portable electric space heater was found plugged in and turned on in resident room 215. On 11/19/2021 at 9:38 AM, observation revealed two portable electric space heaters were found plugged in and turned on in resident room 203. On 11/19/2021 at 10:51 AM, an interview with the Administrator verified that the space heaters were put in use as early as 10/29/2021.	K 781	All staff who have reported to work since 11/19/2021 were verbally educated on the policy prohibiting space heater use; remaining staff were educated on 11/22/21 either in person or electronically. Quality Assurance Observational audits will be conducted in all resident rooms daily x5 for one week, weekly for 4 weeks, then monthly x3 months and quarterly thereafter; or until 100% compliance is achieved. DON, IP or designee are responsible for compliance and these audits will be reviewed at the QAPI meetings.	

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K 781	Continued From page 6 The immediate jeopardy that began on 10/29/2021, was removed on 11/19/2021, when the facility relocated all residents from the portion of the building that had a heating loss to the portion of the building that had an operational heating plant. The deficient practice was corrected on 11/19/2021 when the space heaters in the idenitifed rooms were discontinued from use and removed from the resident rooms.	K 781		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 8, 2021

Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, MN 55063

Re: State Nursing Home Licensing Orders
Event ID: CPMB11

Dear Administrator:

The above facility was surveyed on November 19, 2021 through November 22, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Terri Ament, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Office: (218) 302-6151 Mobile: (218) 766-2720

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

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	00451	A. BUILDING: _____ B. WING _____	C 11/22/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/19/21, through 11/22/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date	2 000		

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2 000	Continued From page 1 when they will be completed. The following complaint was found to be SUBSTANTIATED: H5374026C (MN78582, MN78057) with with licensing orders issued at 4658.0040 Subp. 1-7, 4658.0700 Subp. 2 D, 4658.0710 Subp 3 A, and 4658.1400. The Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
21225	MN Rule 4658.0700 Subp. 2 A Medical Director; Duties Develop res care P&P Subp. 2. Duties. The medical director, in conjunction with the administrator and the director of nursing services, must be responsible for: A. the development of resident care policies and procedures that are to be approved by the licensee; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a policy and procedure defining the responsibilities of the Medical Director. This had the potential to affect all 24 residents residing at the facility. Findings include: On 11/22/21, at 11:13 a.m, facility policies were reviewed. The policies lacked a procedure for responsibilities of the Medical Director. On 11/22/21, at 11:50 a.m. the administrator was interviewed and stated she was unable to locate a policy or procedure addressing The responsibilities of the Medical Director. The administrator stated she could not locate the policy and procedure, and she was unsure if they had this policy.	21225	Corrected	12/14/21

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21225	Continued From page 3 SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop, review, and/or revise policies and procedures that addresses Medical Director duties. The administrator, DON, or designee could educate all appropriate staff on the policies and procedures for the duties of the Medical Director. The administrator, DON, or designee could develop monitoring systems to ensure ongoing compliance with the Medical Director. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21225		
21240	MN Rule 4658.0700 Subp. 2 D Medical Director; coordination Subp. 2. Duties. The medical director, in conjunction with the administrator and the director of nursing services, must be responsible for: D. the medical direction and coordination of medical care in the nursing home, including serving as liaison with attending physicians, and periodic evaluation of the adequacy and appropriateness of health professional and supportive staff and services to meet the medical needs of residents; This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a policy and procedure	21240	Corrected	12/14/21

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21240	Continued From page 4 for physician delegation of tasks for disciplines working under the physician's supervision. This had the potential to affect all 24 residents residing at the facility. Findings include: On 11/22/21, at 11:13 a.m, facility policies were reviewed. The policies lacked a procedure for physician delegation of tasks. On 11/22/21, at 11:50 a.m. the administrator was interviewed and stated she was unable to locate a policy or procedure addressing physician delegation of tasks. The administrator stated she was not able to locate the policy and procedure, and she was not sure if the facility had this policy and procedure. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop, review, and/or revise policies and procedures for provider delegation of tasks to other disciplines. The administrator, DON, or designee could educate all appropriate staff on the policies and procedures for provider delegation of tasks. The administrator, DON, or designee could develop monitoring systems to ensure ongoing compliance with delegation policies. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21240		
21290	MN Rule 4658.0710 Subp. 3 A AdmissionOrders & Physician Evaluations	21290		12/10/21

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21290	Continued From page 5 Subp. 3. Frequency of physician evaluations. A. A resident must be evaluated by a physician at least once every 30 days for the first 90 days after admission, and then whenever medically necessary. A physician visit is considered timely if it occurs within ten days after the date the visit was required. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide a current policy addressing addressing physician visits and requirements for residents to seen every 30 days for the first 90 days, and every 60 days thereafter. This had the potential to effect all 24 residents residing at the facility. Findings include: On 11/22/21, at 11:13 a.m, facility policies were reviewed. The facility Protocol for Regulatory Nursing Home Visits policy was not dated or signed. The policy addressed manditory provider visits which a physican group, however, the facility was no longer contracted with that group. On 11/22/21, at 11:50 a.m. the administrator was interviewed and stated she unsure why the policy was not signed or dated. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop, review, and/or revise policies and procedures for provider frequency of visits.	21290	Corrected	

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21290	Continued From page 6 The administrator, DON, or designee could educate all appropriate staff on the policies and procedures for provider frequency of visits. The administrator, DON, or designee could develop monitoring systems to ensure ongoing compliance of provider frequency of visits. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21290		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe and comfortable room temperature for 18 of 24 residents (R1, R2, R7, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, and R23) who resided on the North wing and reviewed for temperature concerns. Findings include: On 11/19/21, at 9:12 a.m. the north hallway was observed with the fire marshal (FM)-A. Resident rooms were observed and space heaters were found in 10 resident rooms. Low wall heaters in resident rooms were cold to the touch. The hallway, dayrooms, and resident rooms felt cold. Residents were observed in both their rooms and dayroom wearing heavy clothing and blankets	21665	Corrected	12/14/21

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21665	Continued From page 7	21665		

over their laps. Intake and output vents were noted to have no air flow or heat output. The majority of the vents were closed off in the hallway, dayrooms, and resident rooms.

On 11/19/21, at 9:53 a.m. the north boiler room was observed with FM-A. There were four gas furnaces which were not operating. FM-A stated they appeared to be in "locked-out" indicating the furnaces shut themselves down after detecting a problem with how the furnace was functioning.

On 11/19/21, from 10:54 a.m. until 11:17 a.m. room temperature readings on the North wing were observed with the director of nursing (DON). The DON stated she didn't know the date the facility became cold and they started using space heaters, as some residents brought in their own. The DON recorded the following temperatures in occupied resident rooms on the North wing:

10:54 a.m. room 233, 58.2 degrees Fahrenheit (F).
10:57 a.m. room 226, 64.5 degrees F.
10:57 a.m. room 225, 62.3 degrees F.
10:59 a.m. room 223, 66.6 degrees F.
11:00 a.m. room 235, 66.3 degrees F.
11:01 a.m. room 236, 62.7 degrees F.
11:07 a.m. room 221, 65.1 degrees F.
11:09 a.m. room 201, 66.2 degrees F.
11:10 a.m. room 215, 70.7 degrees F.
11:10 a.m. room 202, 70.7 degrees F.
11:11 a.m. room 214, 68.4 degrees F.
11:13 a.m. room 204, 67.9 degrees F.
11:16 a.m. room 205, 68.2 degrees F.
11:17 a.m. room 206, 68.4 degrees F.

On 11/19/21, at 10:40 a.m. R2 was interviewed and stated the heating was "horse *." R2 stated his room heater was never on or working. R2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00451	A. BUILDING: _____ B. WING _____	C 11/22/2021

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

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stated the only way he could keep his room warm was with the use of a space heater. R2 stated his bathroom was very cold. R2 stated he told the staff "constantly" about the cold temperatures, and the facility told him a new boiler had been installed. R2 stated he had not noticed a difference in his room temperature, it was still cold. R2 was observed wearing a heavy blanket over his legs.

On 11/19/21, at 10:47 a.m. R14 was interviewed. R14 stated his bathroom got very cold. R14 stated the heating in his room really didn't work, and he did not have any heat source.

On 11/19/21, at 10:51 a.m. the administrator was interviewed and stated she was not sure how long the heat had been off. The administrator stated the facility had ordered eight new boilers; four had already arrived and were installed. The administrator stated they were still waiting for the other four boilers to arrive for installation.

On 11/19/21, at 11:48 a.m. the administrator stated she was "pretty sure" the furnaces were turned off in May of 2021 and functioning at that time. The administrator stated on 3/22/21, the facility obtained an estimate from a company to install the new furnaces. The administrator stated the company notified the facility in July of 2021 they didn't have enough staff to install the equipment. The administrator stated the facility then contacted a different company who ordered the new boilers and agreed to perform the installation. The administrator stated on 11/9/21, the four installed furnaces were operational after a delay in needed parts and installation. The administrator provided an invoice from the company dated 10/26/21, indicating services provided, "Labor and Materials at Lakeside

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	00451	A. BUILDING: _____ B. WING _____	C 11/22/2021

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21665	Continued From page 9 Medical Boiler Room North." The administrator stated they started using space heaters on 10/29/21, and also purchased five additional space heaters from a store on 11/3/21, for use in the facility until the furnaces were functional. On 11/19/21, at 12:40 p.m. R1 was interviewed and stated the facility was very cold. R1 stated the heat hadn't worked for a long time, he wasn't sure, but believed it may have stopped working as far back as the past winter. R1 stated the space heater made his room warmer, but it was still was too cold for him. R1 stated he used multiple blankets to keep himself warm in his bed. On 11/19/21, at 1:05 p.m. the administrator was interviewed with natural gas employee (NGE)-A and FM-A present. NGE-A stated the new furnaces were not functioning properly due to being installed incorrectly. NGE-A stated the furnaces shut down on their own due to the incorrect installation. The administrator stated she was not aware the furnaces were not functioning. A policy addressing comfortable room temperatures was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could develop, review, and/or revise policies and procedures with required action to be taken by the facility in the event that the temperature in the facility is not manageable due to their furnace or air conditioning stop working. The administrator, DON, or designee could educate all appropriate staff on the policies and procedures addressing temperature control.	21665		

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21665	Continued From page 10 The administrator, DON, or designee could develop monitoring systems to ensure ongoing compliance with a maintaining a safe and comforable environment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		