



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered  
September 27, 2023

Administrator  
Lakewood Health System  
401 Prairie Avenue Northeast  
Staples, MN 56479

RE: CCN: 245420  
Cycle Start Date: August 11, 2023

Dear Administrator:

On September 25, 2023, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, MN 55164-0900  
Telephone: 651-201-4308 Fax: 651-215-9697  
Email: sarah.lane@state.mn.us



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered  
August 30, 2023

Administrator  
Lakewood Health System  
401 Prairie Avenue Northeast  
Staples, MN 56479

RE: CCN: 245420  
Cycle Start Date: August 11, 2023

Dear Administrator:

On August 11, 2023, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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.

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.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

#### DEPARTMENT CONTACT

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

Susie Haben, Rapid Response  
Licensing and Certification Program  
Health Regulation Division  
Minnesota Department of Health  
Midtown Square  
3333 Division Street, Suite 212  
Saint Cloud, Minnesota 56301-4557  
Email: [susie.haben@state.mn.us](mailto:susie.haben@state.mn.us)  
Office: (320) 223-7356 Mobile: (651) 230-2334

#### 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 the 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by November 11, 2023 (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).

In addition, if substantial compliance with the regulations is not verified by February 11, 2024 (six months after

Lakewood Health System

August 30, 2023

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the identification of noncompliance) your provider agreement will be terminated. 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.

#### 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](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 electronic 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](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.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, MN 55164-0900  
Telephone: 651-201-4308 Fax: 651-215-9697  
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August 30, 2023

Administrator  
Lakewood Health System  
401 Prairie Avenue Northeast  
Staples, MN 56479

Re: Event ID: SVOH11

Dear Administrator:

The above facility survey was completed on August 11, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst  
Federal Enforcement | Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64900  
Saint Paul, MN 55164-0900  
Telephone: 651-201-4308 Fax: 651-215-9697  
Email: sarah.lane@state.mn.us

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

PRINTED: 09/20/2023  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245420</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/11/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKWOOD HEALTH SYSTEM</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479</b>		
(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	<p><b>INITIAL COMMENTS</b></p> <p>On 8/10/23 through 8/11/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed during the survey:</p> <p>H54204424C (MN95744);</p> <p>H54204457C (MN94222);</p> <p>H54204410C (MN95569), with a deficiency issued at F695.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F 000			
F 695 SS=D	<p>Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)</p> <p>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.</p>	F 695		9/9/23	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/09/2023

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 695	<p>Continued From page 1</p> <p>The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, observation and document review, the facility failed to implement assessed intervention to prevent reoccurrence following a respiratory care incident and facility failed to develop a respiratory care plan for 1 of 4 residents (R2) reviewed for respiratory care.</p> <p>Findings include:</p> <p>R2's admission Minimal Data Set (MDS) dated 5/23/23, identified R2 had diagnoses which included paraplegia, chronic obstructive pulmonary disease (COPD), and respiratory failure. Further MDS identified required the use of oxygen (O2) therapy.</p> <p>R2's Order Summary dated 8/14/23, indicated R2 required O2 between 0-2 liters as needed to keep O2 saturation about 90% and nurse to check O2 tank prior to meals and change promptly if needed.</p> <p>R2's care plan dated 8/10/23, lacked evidence of a respiratory plan of care or any respiratory interventions which included: type of O2 delivery system, when to administer O2, equipment settings for prescribed flow rates, monitoring O2 levels and resident risks and monitoring for complications.</p>	F 695	<p>This facility will implement the practice of monitoring oxygen tank levels TID to ensure residents have appropriate oxygen flow throughout the day. Will add to TAR for each resident on oxygen, will audit this weekly, and present to QAPI Team monthly. Goal is 100% of residents on oxygen will have this monitored TID.</p> <p>This facility will educate each staff member, per their role-PCA/CNA, TMA, LPN, RN; on the process of changing over the oxygen tank or administering oxygen, appropriate to their role within 30 days of POC submission and present to QAPI with results.</p> <p>This facility will implement a respiratory section of the care plan for each resident that is on oxygen to ensure the appropriate care is being provided to each resident with oxygen. This will be audited weekly and presented to QAPI Team monthly. Goal is 100% of residents on oxygen will have this care plan section in place.</p>	

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

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F 695	<p>Continued From page 2</p> <p>Review of facility report to the state agency (SA) dated 7/27/23, included nursing assistant (NA) reported to the licensed practical nurse (LPN)-A prior to breakfast R2 need more oxygen in her portable tank. R2 was brought into the dining room and tablemate asked a trained medication assistant (TMA) to get R2 oxygen. R2 was upset she did not get her oxygen right away. R2 reported LPN-A was not friendly and was crying and visibly upset.</p> <p>Review of facility's 5-day investigation submitted to the SA on 7/28/23, identified investigation verified R2 was out of oxygen however R2's saturations were at an acceptable level per physician orders and R2 appeared clinically stable. Further, investigation identified there were interventions put into place to prevent further issues.</p> <p>Review of an email sent by director of nursing (DON) sent to all nursing staff dated 7/31/23, directed staff to do the following:</p> <ul style="list-style-type: none"> <li>- only a nurse or a TMA can change O2 tanks over and do anything with them. A NA cannot move oxygen from tanks, adjust tanks, ect.</li> <li>- Nurses and TMAs need to check the O2 fill level to ensure it has O2 in it prior to changing the resident over to the tank. Staff can't put someone on O2 when there isn't any oxygen in it.</li> <li>- The order is for continuous O2 for a reason, so the resident cannot have a gap in O2</li> <li>- If staff note the resident is running low, please bring them to a nurse and have them sit with the nurse to avoid them running out or the nurse forgetting to fill their tank.</li> <li>- If they are in their room and need to be changed over, use the nurse light system so the nurse is reminded that they need to change the</li> </ul>	F 695		

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F 695	<p>Continued From page 3 resident over.</p> <p>On 8/10/23 at 3:27 p.m., R2 was observed in her room in wheelchair and was hooked to the portable O2 tank on the back of her wheelchair by nasal cannula. R2 stated on 7/27/23, the NA that assisted with morning cares hooked her up to the portable O2 tank and brought her to the nurses cart and reported to the nurse she needed more O2 and then the NA took her to the dining room. R2 stated she ate breakfast and waited a while when another nurse noticed she did not have her O2 on and got her a new tank. R2 stated she felt the nurse "has it in for me".</p> <p>On 8/10/23 at 3:58 p.m., registered nurse (RN)-D stated only licensed nurses or TMAs can switch and/or touch O2, the NAs were expected to notify the nurse to switch a resident's O2 source.</p> <p>On 8/10/23 at 5:57 p.m., NA-A indicated on the day of 7/27/23, NA-A confirmed she had switched R2 from the room concentrator to the portable tank and brought R2 out of her room with the empty tank, notified LPN-A R2's tank was empty, and then brought R2 into the dining room, however R2's tank was never changed by LPN-A. Further, NA-A stated if a resident required O2 it would be identified in their care plan along with if the resident required O2 continuously or as needed. In addition, NA-A stated NAs were allowed to change O2 source, turn on/off O2, and set the concentrator or portable tank to flow rate, which NA-A would compare what it was previously set at, but NAs were not allowed to increase the flow rate.</p> <p>On 8/10/23 at 6:16 p.m., RN-A indicated R2 was admitted to the facility on hospice care with</p>	F 695		

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F 695	<p>Continued From page 4</p> <p>orders for O2 as needed related to diagnosis of respiratory failure with hypoxia. RN-A indicated R2 did wear her O2 almost continuously for comfort. Further, RN-A stated on 7/27/23, R2 was brought into RN-A's office by TMA-A and R2 appeared to be upset she didn't have oxygen and crying and R2 reported "the nurse has it out for me". RN-A reported R2 was not in respiratory distress and upon assessment revealed R2's O2 saturation was 96% and lung sounds were clear. In addition, RN-A stated only licensed nurses or TMAs were allowed to do anything with O2 since O2 was considered a medication/treatment and NAs should not do anything with O2.</p> <p>On 8/11/23 at 8:35 a.m., RN-C stated only licensed nurses or TMAs were able to touch O2, switch O2 sources, or adjust O2 flow rate but sometimes the NAs forget and would bring residents out of their rooms and notify the nurse the resident needed oxygen and continue to bring them to the dining room. Further, RN-C indicated a big education was sent to all nursing staff directing staff to leave the residents in their rooms and notify the nurse when they were ready to leave their room and they need their oxygen.</p> <p>On 8/11/23 at 8:56 a.m., LPN-A residents who required O2 had orders and were monitored as well as ensuring their portable tank were full before switching O2 sources and would be completed by either the licensed nurse on duty or TMA the NAs were not allowed to touch the O2. LPN-A indicated on 7/27/23, in the morning it was busy, and NA-A notified LPN-A R2 needed a new O2 tank as hers was empty while passing by and NA-A brought R2 into the dining room. LPN-A indicated R2 became upset she did not have oxygen on and the NA-A had left her with no</p>	F 695		

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F 695	<p>Continued From page 5</p> <p>oxygen. Further, LPN-A indicated there was a failure that occurred, and this incident could have been prevented had the NA alerted LPN-A while R2 was still in room hooked up to room concentrator. LPN-A indicated education was sent out to all nursing staff related to NAs not touching O2 and to alert licensed nurse or TMA prior to moving the resident out of the room as well as checking R2's tanks more frequently to ensure it is full.</p> <p>On 8/11/23 at 11:26 a.m., TMA-A stated on 7/27/23, R2 was in the dining room at a table with another resident who got TMA-A's attention and reported R2 needed her oxygen. TMA-A went and got a new portable O2 tank and brought R2 into RN-A's office. TMA-A reported R2 was upset but did not appear to be in repertory distress. Further, TMA-A indicated since this incident the DON had sent an email to all nursing staff related to only licensed nurses or TMAs were allowed to change O2 sources or adjust O2 and NAs were not allowed to touch the O2.</p> <p>On 8/11/23 at 11:44 a.m. NA-B indicated she was allowed to switch O2 sources for residents as well as turn on/off oxygen. Further, NA-B will ask a verbal resident if they require oxygen and if they are unable to tell staff NA-B would ask a nurse.</p> <p>On 8/11/23 at 12:19 p.m., NA-C indicated NAs were allowed to turn on/off O2 and change O2 sources for example if a resident was on the room concentrator NA-C would assist with transferring to the wheelchair and turn on the O2 portable tank which was typically already set to 2 liters.</p> <p>On 8/11/23 at 12:23 p.m., TMA-B indicated if a</p>	F 695		

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F 695	<p>Continued From page 6</p> <p>resident required O2 it would be listed on their care plan and the care plans are posted in each resident's closet. Further, TMA-B stated only licensed nurse and TMAs were allowed to touch O2 and the NAs were not supposed to be changing O2 sources.</p> <p>On 8/11/23 at 2:52 p.m., RN-B indicated due to the incident with R2, DON sent out education to all nursing staff on the recent changes which were only licensed nurses and TMAs would be able to do anything with O2.</p> <p>On 8/11/23 at 2:41 p.m., RN-A stated on 7/27/23, R2 was brought into her office and appeared to be upset with tears coming down her face and appeared to be gasping from crying (not in respiratory distress). Through the investigation, RN-A stated it was determined R2 had been without O2 for approximately 20 minutes. Further, RN-A stated anxiety with or without respiratory distress could cause someone to hyperventilate or have air hunger. In addition, RN-A stated each resident who required O2 should have a care plan within 30 days of admission with respiratory inventions for staff direction that are placed on the Kardex as well, but confirmed R2 did not have a respiratory care plan due to miscommunication of staff when R2 switched care coordinators.</p> <p>On 8/15/23 at 10:40 a.m., DON indicated the NA-B reported to LPN-A R2's tank was almost empty and brought R2 into the dining room and left R2 at the table where the tank eventually went empty. DON stated NA-B should have alerted another nurse regarding R2's tank being close to empty if LPN-A was busy. Further, DON stated following the incident the interdisciplinary team met and implemented the licensed nurse would</p>	F 695		

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245420</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>08/11/2023</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKWOOD HEALTH SYSTEM</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479</b>		
(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 695	<p>Continued From page 7</p> <p>check the tank before each meal. DON stated there was a miscommunication regarding the email that was sent to all staff on 7/31/23 and stated the facility did not change their process and NA's were able to switch O2 sources but were not trained to adjust the O2 flow rate. In addition, DON stated RN care coordinators and MDS nurse would be expected to collaborate and complete a comprehensive assessment for each resident which would include a respiratory care plan.</p> <p>Review of facility policy titled Oxygen administration, long term revised 11/28/22, lacked direction on which staff were allowed to assist with O2 as well as implementing a respiratory care plan and interventions required.</p>	F 695		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>00667</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/11/2023</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAKWOOD HEALTH SYSTEM</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479</b>
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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;"><b>NH LICENSING CORRECTION ORDER</b></p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 8/10/23 through 8/11/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>09/09/23</b>
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Minnesota Department of Health

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2 000	<p>Continued From page 1</p> <p>The following complaints were reviewed during the survey:</p> <p>H54204424C (MN95744);</p> <p>H54204410C (MN95569);</p> <p>H54204457C (MN94222).</p> <p>Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software.</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		