DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 27, 2021

Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN 56623

RE: CCN: 245580
Cycle Start Date: August 9, 2021

Dear Administrator:

On August 27, 2021, we notified you a remedy was imposed. On September 15, 2021 the Minnesota Department of Health 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 September 10, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective November 9, 2021 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 27, 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 November 9, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on September 10, 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 Therefore, the NATCEP prohibition is rescinded.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

Electronically delivered
August 27, 2021

Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN 56623

RE: CCN: 245580
Cycle Start Date: August 9, 2021

Dear Administrator:

On August 9, 2021, 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 delivered CMS-2567, whereby significant corrections are required.

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(ies) 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:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 9, 2021.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 9, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 9, 2021.

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.

If you have not achieved substantial compliance by November 9, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lakewood Care Center will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from November 9, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. 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), 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
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 - Health Regulation Division 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 February 9, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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

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.

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 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

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,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245580	A. BUILDING _____ B. WING _____	C 08/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEWOOD CARE CENTER	**600 MAIN AVENUE SOUTH BAUDETTE, MN 56623**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/9/21 and 8/10/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5580013C (MN75323), with a deficiency cited at F580. As a result of the survey an additional deficiency was cited at F880. 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. 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.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;	F 580		9/9/21

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

Electronically Signed | 09/03/2021

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F 580	Continued From page 1 (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations	F 580		

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F 580	Continued From page 2 under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interview and document review the failed failed to timely notify the physician of a change of condition for 1 of 3 residents (R1) reviewed for change of condition. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/15/21, identified severe cognitive impairment. The MDS indicated R1 was dependent on staff for transfers, toileting and bed mobility. R1's undated Admission Record identified diagnosis included: cerebral infarction, diverticulosis, hypokolemia, hypotension and shortness of breath. R1's care plan dated 6/21/21, identified advance directive: DNR (do not resuscitate)/ DNI (do not intubate). the care plan directed staff to review advance directives with family quarterly and as needed. The care plan further identified an respiratory function alteration and indicated he would be free from signs and symptoms of respiratory distress. R1's Emergency Resuscitation Guidelines dated 10/14/11, indicated DNR/DNI, no cardiopulmonary resuscitation. No 911 for cardiopulmonary arrest. May call 911 for urgent needs and may call ambulance for routine transport. May call medical doctor or registered nurse. Will provide active treatment up to the point of cardiopulmonary arrest. R1's Progress Notes identified the following: - 6/26/21, 6:49 p.m. R1 was resting in a chair	F 580	LakeWood Care Center does notify the physician of a change in condition for our residents per our Notification of Changes policy. The facility does recognize that during the survey on 8/9/2021; Resident 1 (R1) had a change in condition on 6/26/2021 at 6:54pm. At 9:51pm, family was called to be notified of R1's change in condition. 1. Regarding R1, the facility has completed review of the resident's medical record. All further changes in condition of the resident did have physician notification. Since the survey, R1 did expire with comfort cares with family at his side. Completed 9/2/21. 2. Regarding all other residents who reside in the facility who might be affected by this deficient practice; the facility has reviewed their medical records to assure that physicians and/or resident families have been notified of residents that have had a change in condition. The facility will review the communication/collaboration process with staff and other supporting entities so that this facility can work as a team to identify resident changes and ensure notification to physician and/or resident representative are completed per policy. 3. To assure that this deficient practice does not occur in the future, the facility will complete training for those staff members	

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F 580	Continued From page 3 after lunch. Noticed R1 snoring as he was sleeping. Five minutes later R1 was "noticed as not breathing." Vital signs were checked and R1 opened his eyes and stated he was tired. Just before shift change R1 was assessed by nurse and R1 was noted to be "belly breathing" which had decreased to five times per minute. R1's oxygen saturation levels decreased from 99% to 90%, then would begin "belly breathing" again. - 6/26/21, 9:51 p.m. Previous nurse called R1's family in regard to previous status. Family arrived to visit. R1's family member requested R1 be seen by the physician due to periods of apnea (temporary cessation of breathing, especially during sleep). On call provider was notified at that time. During interview on 8/10/21, at 9:49 a.m. licensed practical nurse (LPN)-A stated she was the nurse who cared for R1 during the day shift on 6/26/21. LPN-A stated she was doing some charting after lunch and one of the nursing assistants walked by and said R1 was not breathing. Both herself and RN-A got up to assess and R1 started "coming back." LPN-A stated RN-A knew R1 better and told her apnea was not abnormal for him. R1 was put to bed and monitored and as the day progressed he continued to display more signs of apnea. From dinner time to about 6:30 p.m. the next nurse came in and LPN-A explained to her about the periods of apnea. - LPN-A said both nurses went in to check on R1 and his respiration were between 8-10 breaths per minute, his skin was beginning to mottle and his legs were "super cold." LPN-A said she called R1's family and told them R1's respirations had decreased and he had been having periods of not	F 580	responsible to this regulatory tag. The training includes: a. Implementing, training and review of Notification of Changes Binders which includes the following: i. Notification of Changes Guidelines ii. Notification of Changes Policy iii. Notification of Changes Post-Test b. Training will be completed by 9/9/21. 4. To ensure that the deficient practice is being corrected and will not recur, the nursing leadership (RN Care Coordinators and Director of Nursing) will monitor its corrective actions by: a. DON to audit all resident changes (injury/decline/room, etc) as they occur for the next 3 months and ensure that the facility staff immediately informs the resident, consults the resident's physician, and the resident representative. b. To ensure this corrected practice is sustainable and hardwired, nursing leadership will complete daily audits daily for 2 weeks, twice a week for 2 weeks, then weekly for the 2 weeks, then every other week for a month. c. The leadership team will continue to monitor changes at weekly High Risk meetings. d. The audits will be a new PDSA for our QAPI meetings. 5. Will be completed by 9/9/21.	

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F 580	Continued From page 4	F 580		

breathing lasting 15 - 20 seconds and it was getting worse with shallow respirations and changing skin color. LPN-A stated family asked her if he was dying and she replied she thought it might be his time. LPN-A had not notified the physician of R1's change of condition. LPN-A stated R1 was a DNR/DNI which meant in the event of cardiac arrest they would not initiate CPR. In her mind there was nothing that could be done in the emergency room and in her nursing judgement she felt it was time to just accept what was happening. LPN-A stated because RN-A had told her the apnea was normal, she felt it was okay then when R1 began mottling she felt it was past the point of having anyone do anything further. LPN-A stated she should have called the physician on call.

-At 10:36 a.m. RN-A stated she was present on June 26th and recalled a NA saying R1 was not breathing, RN-A stated R1 had apneic periods at times and LPN-A and herself check his vitals and he began talking to them. R1 was having some apnea and said LPN-A was directed to keep and eye on him and if he got worse send him to the ER. RN-A told LPN-A the apneic periods were normal for R1. Further, the on call physician should have been called.

At 10:45 a.m. the director of nursing (DON) stated she spoke with LPN-A who stated family were contacted due to R1's change of condition. The physician should have been contacted for instructions or R1 should have been sent to the ER. The DON stated LPN-A was re-educated and she planned to do education with all staff at the next staff meeting.

A facility policy related to notification to the

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F 580	Continued From page 5 physician for a change of condition was requested but not received.	F 580		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported;	F 880		9/10/21

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F 880	Continued From page 6 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate hand hygiene was completed during personal care for 1 of 1 resident (R1) who's cares were observed. Findings include:	F 880	LakeWood Care Center does provide adequate hand hygiene for our residents per our Infection Control - Hand Hygiene policy. The facility does recognize that during the survey on 8/9/2021; During perineal cares for Resident 1 (R1), NA-A did not perform hand hygiene per the	

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F 880	Continued From page 7 R1's quarterly Minimum Data Set dated 6/16/21, indicated he was incontinent of bowel and bladder and was dependent on staff to perform bed mobility, transfers, toileting and personal hygiene. R1's care plan dated 6/21/21, identified a self care deficit and incontinence and directed staff to provide perineal care as R1 was unable to participate. During observation on 8/9/21, at 12:5 p.m. R1 was seated in a recliner chair in the hallway outside his room. R1 had a large dark area on his pants between his legs. Nursing assistant (NA)-A and NA-B assisted R1 to his room and placed him on his bed to perform toileting assistance and put clean gloves on. NA-A and NA-B removed R1's pants and brief which were saturated with yellow-brown colored stool. NA-A washed R1's perineal area, removing the stool. NA-A and NA-B rolled R1 onto his side and without changing gloves or performing hand hygiene, NA-A touched R1's shirt and legs. NA-B changed gloves and washed hands and assisted NA-A to remove the sling from under R1, removed R1's soiled sheets, touched his pillow case and assisted to place a clean brief on R1. NA-A, still without changing gloves or performing hand hygiene, assisted NA-B to place clean bed linens under R1 and covered him with a blanket. After being prompted by NA-B, NA-A changed her gloves but did not perform hand hygiene, adjusted the bed using the remote and adjusted his fall mats. During interview on 8/9/21, at 1:09 p.m. NA-A stated "I should be changing my gloves more". On 8/10/21, at 11:20 a.m. the director of nursing stated when performing perineal care staff should	F 880	facility policy. 1. Regarding R1, the facility has completed review of the resident's medical record. Since the survey, R1 did not develop any communicable diseases or illnesses. 2. Regarding all other residents who reside in the facility who might be affected by this deficient practice; the facility has reviewed their medical records and have concluded that there have not been any communicable diseases or illnesses since the survey date. The facility will ensure that all care center staff understand the updated regulation that guides our practices regarding Infection Control – Hand Hygiene, identify the 2 types of Hand Hygiene, and be able to identify the role and responsibilities of all staff with Hand Hygiene. 3. The facility's Quality Assurance and Performance Improvement Committee with assistance from the Infection Preventionist, and leadership oversight will conduct a root cause analysis (RCA) to identify the problem(s) that resulted in this deficiency and develop intervention or corrective action plan to prevent recurrence. 4. Hand hygiene policies and procedures will be reviewed to ensure they meet CDC guidance and CMS requirements and revised as needed. 5. The Infection Preventionist, Director	

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	245580	A. BUILDING _____ B. WING _____	C 08/09/2021

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F 880	Continued From page 8 change gloves and perform hand hygiene when going from dirty to clean. A facility policy Hand hygiene, dated 12/20, directed staff to perform hand hygiene when coming on duty, when grossly contaminated and before and after providing direct patient care. The policy further directed staff to removed gloves immediately after providing care to a contaminated part of the body, before touching clean areas such as patient clothing or hard surfaces.	F 880	of Nursing and Clinical Education Coordinator will implement competency assessments for staff on proper hand hygiene and develop a system to ensure all staff have received the training and are competent. 6. The Director of Nursing, the Infection Preventionist and/or other facility leadership will conduct audits on all shifts, every day for one week, then may decrease the frequency based upon compliance. Audits should continue until 100% compliance is met. 7. The Director of Nursing, Infection Preventionist or designee will review the results of audits and monitoring with the Quality Assurance Program Improvement (QAPI) program.	

Electronically delivered
August 27, 2021

Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN 56623

Re: State Nursing Home Licensing Orders
Event ID: BY3911

Dear Administrator:

The above facility was surveyed on August 9, 2021 through August 9, 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:

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
Office: (320) 223-7356 Mobile: (651) 230-2334

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
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00332	A. BUILDING: _____ B. WING _____	C 08/09/2021

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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 8/9/21 and 8/10/21, 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 when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5580013C (MN75323) with a licensing order issued at MN Rule 4658.0085 As a result of the investigation an additional citation was issued at MN Rule 4658.0800 Subp. 4 A 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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form	2 265		9/10/21

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2 265	Continued From page 3 of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review the failed failed to timely notify the physician of a change of condition for 1 of 3 residents (R1) reviewed for change of condition. Findings include: R1's quarterly Minimum Data Set (MDS) dated 6/15/21, identified severe cognitive impairment. The MDS indicated R1 was dependent on staff for transfers, toileting and bed mobility. R1's undated Admission Record identified diagnosis included: cerebral infarction, diverticulosis, hypokolemia, hypotension and shortness of breath. R1's care plan dated 6/21/21, identified advance directive: DNR (do not resuscitate)/ DNI (do not intubate). the care plan directed staff to review advance directives with family quarterly and as needed. The care plan further identified an respiratory function alteration and indicated he would be free from signs and symptoms of respiratory distress. R1's Emergency Resuscitation Guidelines dated 10/14/11, indicated DNR/DNI, no cardiopulmonary resuscitation. No 911 for cardiopulmonary arrest. May call 911 for urgent	2 265	CORRECTED	

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2 265	Continued From page 4	2 265		

needs and may call ambulance for routine transport. May call medical doctor or registered nurse. Will provide active treatment up to the point of cardiopulmonary arrest.

R1's Progress Notes identified the following:

- 6/26/21, 6:49 p.m. R1 was resting in a chair after lunch. Noticed R1 snoring as he was sleeping. Five minutes later R1 was "noticed as not breathing." Vital signs were checked and R1 opened his eyes and stated he was tired. Just before shift change R1 was assessed by nurse and R1 was noted to be "belly breathing" which had decreased to five times per minute. R1's oxygen saturation levels decreased from 99% to 90%, then would begin "belly breathing" again.

- 6/26/21, 9:51 p.m. Previous nurse called R1's family in regard to previous status. Family arrived to visit. R1's family member requested R1 be seen by the physician due to periods of apnea (temporary cessation of breathing, especially during sleep). On call provider was notified at that time.

During interview on 8/10/21, at 9:49 a.m. licensed practical nurse (LPN)-A stated she was the nurse who cared for R1 during the day shift on 6/26/21. LPN-A stated she was doing some charting after lunch and one of the nursing assistants walked by and said R1 was not breathing. Both herself and RN-A got up to assess and R1 started "coming back." LPN-A stated RN-A knew R1 better and told her apnea was not abnormal for him. R1 was put to bed and monitored and as the day progressed he continued to display more signs of apnea. From dinner time to about 6:30 p.m. the next nurse came in and LPN-A explained to her about the periods of apnea.

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2 265	Continued From page 5 - LPN-A said both nurses went in to check on R1 and his respiration were between 8-10 breaths per minute, his skin was beginning to mottle and his legs were "super cold." LPN-A said she called R1's family and told them R1's respirations had decreased and he had been having periods of not breathing lasting 15 - 20 seconds and it was getting worse with shallow respirations and changing skin color. LPN-A stated family asked her if he was dying and she replied she thought it might be his time. LPN-A had not notified the physician of R1's change of condition. LPN-A stated R1 was a DNR/DNI which meant in the event of cardiac arrest they would not initiate CPR. In her mind there was nothing that could be done in the emergency room and in her nursing judgement she felt it was time to just accept what was happening. LPN-A stated because RN-A had told her the apnea was normal, she felt it was okay then when R1 began mottling she felt it was past the point of having anyone do anything further. LPN-A stated she should have called the physician on call. -At 10:36 a.m. RN-A stated she was present on June 26th and recalled a NA saying R1 was not breathing, RN-A stated R1 had apneic periods at times and LPN-A and herself check his vitals and he began talking to them. R1 was having some apnea and said LPN-A was directed to keep and eye on him and if he got worse send him to the ER. RN-A told LPN-A the apneic periods were normal for R1. Further, the on call physician should have been called. At 10:45 a.m. the director of nursing (DON) stated she spoke with LPN-A who stated family were contacted due to R1's change of condition. The physician should have been contacted for	2 265		

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2 265	Continued From page 6 instructions or R1 should have been sent to the ER. The DON stated LPN-A was re-educated and she planned to do education with all staff at the next staff meeting. A facility policy related to notification to the physician for a change of condition was requested but not received. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise policies/procedures on notifying medical providers and family regarding significant changes in condition. The DON or designee could educate nursing staff on ensuring the physician and family are notified timely of significant changes in resident condition, then audit charts to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and	21390		9/10/21

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21390	Continued From page 7 procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate hand hygiene was completed during personal care for 1 of 1 resident (R1) who's cares were observed. Findings include: R1's quarterly Minimum Data Set dated 6/16/21, indicated he was incontinent of bowel and bladder and was dependent on staff to perform bed mobility, transfers, toileting and personal hygiene. R1's care plan dated 6/21/21, identified a self care deficit and incontinence and directed staff to provide perineal care as R1 was unable to participate. During observation on 8/9/21, at 12:5 p.m. R1 was seated in a recliner chair in the hallway outside his room. R1 had a large dark area on his pants between his legs. Nursing assistant (NA)-A and NA-B assisted R1 to his room and placed him on his bed to perform toileting assistance and put clean gloves on. NA-A and NA-B removed	21390	CORRECTED	

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21390	Continued From page 8 R1's pants and brief which were saturated with yellow-brown colored stool. NA-A washed R1's perineal area, removing the stool. NA-A and NA-B rolled R1 onto his side and without changing gloves or performing hand hygiene, NA-A touched R1's shirt and legs. NA-B changed gloves and washed hands and assisted NA-A to remove the sling from under R1, removed R1's soiled sheets, touched his pillow case and assisted to place a clean brief on R1. NA-A, still without changing gloves or performing hand hygiene, assisted NA-B to place clean bed linens under R1 and covered him with a blanket. After being prompted by NA-B, NA-A changed her gloves but did not perform hand hygiene, adjusted the bed using the remote and adjusted his fall mats. During interview on 8/9/21, at 1:09 p.m. NA-A stated "I should be changing my gloves more". On 8/10/21, at 11:20 a.m. the director of nursing stated when performing perineal care staff should change gloves and perform hand hygiene when going from dirty to clean. A facility policy Hand hygiene, dated 12/20, directed staff to perform hand hygiene when coming on duty, when grossly contaminated and before and after providing direct patient care. The policy further directed staff to removed gloves immediately after providing care to a contaminated part of the body, before touching clean areas such as patient clothing or hard surfaces. SUGGESTED METHOD OF CORRECTION: The ICP or designee could review facility policies/procedures regarding appropriate infection control technique during personal cares.	21390		

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21390	Continued From page 9 The ICP or designee could provide staff education regarding the policies and educate staff on appropriate IC technique. The ICP or designee should complete timely audits to ensure policies are being followed to ensure on-going competence. The ICP, or designee should take education verifications and the audits to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for continued monitoring. TIME PERIOD FOR CORRECTION: 21 (twenty-one) DAYS	21390		