Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 14, 2025

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

RE: CCN: 245580
Cycle Start Date: September 11, 2024

Dear Administrator:

On September 17, 2024, we notified you a remedy was imposed. On January 9, 2025 the Minnesota Departments of Health and Public Safety completed revisits to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of January 8, 2025.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective October 2, 2024 be discontinued as of January 8, 2025. (42 CFR 488.417 (b))

In our letter of September 17, 2024, 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 is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 2, 2024. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 14, 2025

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

Re: Reinspection Results
Event ID: QN3212

Dear Administrator:

On January 9, 2025 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 September 11, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 26, 2024

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

RE: CCN: 245580
Cycle Start Date: September 11, 2024

Dear Administrator:

On September 17, 2024, we informed you of imposed enforcement remedies.

On November 20, 2024, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective October 2, 2024.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS location only if CMS agrees with our recommendation.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective October 2, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 2, 2024.

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.

As we notified you in our letter of September 17, 2024, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 2, 2024.

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.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

DEPARTMENT CONTACT

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

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 March 11, 2025 (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

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:

Steven.Delich@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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: **https://forms.web.health.state.mn.us/form/NHDisputeResolution**

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolutioN

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 11/20/2024

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 11/20/24, 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. The following complaint was reviewed H55801189C (MN00108011). As a result of the survey a deficiency was cited at F604. 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 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse,	F 604		12/30/24

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

Electronically Signed | 12/05/2024

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 604	Continued From page 1 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to identify the use of restraints for 1 of 3 residents (R3) reviewed when the facility used multiple personal alarms and video cameras that restricted R3's movement and failed to attempt alternate interventions to prevent falls. Findings include: R3's Admission Record indicated he re-admitted to the facility 10/23/24, with diagnosis that included history of traumatic brain injury, cerebrovascular disease, depression, and insomnia. R3's significant change Minimum Data Set (MDS) identified moderately impaired cognition. The MDS indicated R3 required partial to moderate	F 604	1. Regarding Resident R3 an alarm audit has been completed. It was determined as evidence by these audits that Resident R3 is cognitively unable to ask or comprehend the need for assistance from staff when it is required related to safety. The social worker and DON met with the guardian/POA for an optimal safety plan. The video surveillance camera was assessed and determined it was not a usable method for safety at this time. Alarm restraint entrapment evaluation has been updated. Comprehensive Medical - Necessity Evaluation by PCP completed to include Appropriate orders in relation to Alarm use. Care plan and education has been updated as well, and will continue to be assessed as changes occur. 2. Regarding all other residents; All	

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F 604	Continued From page 2 assistance for tilting and supervision/touching assistance for transfers and ambulation. R3's care plan dated 10/23/24, identified a self-care deficit related to traumatic brain injury, loss of fingers and thumb and Cerebral vascular accident. The care plan directed staff to provide contact guard assistance for toilet use, transfers and ambulation and indicated He moved very fast and became angry when staff stopped or interrupted. The care plan directed staff to stay by his right side and explain why they were assisting him. The care plan indicated R3 was at high risk for falls and indicated he required an alarm in bed, recliner chair and dining room chair due to inability to comprehend safe choices and ask for assistance. R3 facility progress notes indicated on 10/23/24 occupational therapy completed a room safety evaluation prior to his return and added chime alarms to the bed, recliner, and dining room chair that he sat in. R3 facility progress notes indicated on 10/23/24, R3 admitted back to the facility. R3 had left sided weakness and deficit to his left eye. R3 ambulated with walker and gait belt and required contact guard assistance with transfers and ambulation. Has alarms to his bed, recliner and dining room chair for safety related to cognition and did not always use his walker. R3 facility progress notes indicated on 10/30/24, R3 had a brief episode of yelling and swearing at staff. R3 at times got up and started walking without waiting for help. Reinforced that when alarm goes off it was to let staff know he may need some help. R3 seemed to startle easily.	F 604	residents that have the same or similar identifiers will have alarm use audits and alarm restraint entrapments evaluations updated. 3. To assure this deficient practice does not occur in the future for the facility; The facility will update alarm restraint entrapments evaluations; to include a comprehensive assessment for the use of alarms/cameras. A review and update of the policy for restraints. All Staff will receive education with the review of this policy by 12/20/24. Audits for continued use of alarms will be reviewed on an admission, quarterly, yearly, or with a significant change in status. Education on the new process is to be provided to admitting staff and IDT Team with planned completion by 12/20/2024. 4. To assure this practice enhancement is sustainable and hardwired, Leadership (IE: Director of Nursing, LTC RN Manager, an IDT team member or designee) shall complete audits as follows: DON will audit all Admissions, quarterly, yearly, or with a significant change in status for the completion of this Evaluation as they occur in the next 2 months. Alarm Audits will be conducted by leadership to ensure alarms are not used for staff convenience as follows: Audit 3 times a week starting 12/09/24 for 1 week. Audit 1x weekly starting 12/16/24 for 2 weeks. Audit biweekly starting 12/23/24 for 1 month.	

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F 604	Continued From page 3 A Restraint/Entrapment Assessment dated 10/30/24, identified bed and chair alarms and indicated family wanted the alarms due to recent stroke that caused left side deficit and impaired vision to his left eye. The assessment indicated R3 was unable to make safe decision and required assistance with ambulation. The assessment indicated the alarms were not a restraint. The assessment did not address R3 reaction to the alarms and did not identify alternate interventions attempted prior to initiating the alarms. R3 facility progress notes indicated on 11/9/24, R3 has stood up the chair alarm went off. R3 sat back down but stated when staff approached, "I want to turn this damn thing off," pointing to the alarm. This happened three times. R3 facility progress notes indicated on 11/16/24, R3 was incontinent in the dining room and moved around on the alarm on the chair. Staff offered assistance and R3 was swinging his alarms and throwing his walker around. R3 yelled, those alarms were pissing him off and he was not going to put up with it. R3 facility progress notes indicated on 11/16/24, R3 continued to have behaviors regarding alarms. R3 got very angry that they continue to make noise and yelled at staff that they need to throw the "damn things" in the garbage. Stated they were too loud. During observation on 11/20/24 at 9:18 a.m. R3 was seated at a table in the dining room. R3 removed a pressure pad alarm from underneath him and set it on the table, then placed it on the	F 604	Audit results will be reviewed weekly at ITD: High Risk Meetings and at QAPI meetings for the next 3 months, ending 3/1/2025.	

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F 604	Continued From page 4 floor. Staff responded to the alarm and placed it underneath him. During observation at 9:49 a.m., R3 was viewed on a camera that was placed on a table in the hallway. R3 was lying in bed with the television remote control in his hand and kept looking toward the hallway. At 10:00 a.m. R3 sat up on the side of the bed and looked around. The alarm could be heard sounding and R3 laid back down on the bed. During interview on 11/20/24 at 11:43 a.m., nursing assistant (NA)-A stated the camera was used to monitor R3. NA-A stated R3 was unsteady and needed supervision and staff were unable to provide one to one supervision so the solution was to place a camera in his room. NA-A stated R3 also had alarms in his room that would sound if he got up. NA-A said usually when staff were busy, they place the camera in their pocket and a light would go on to signal if R3 got up. NA-A stated R3 had a pressure pad alarm under him in bed and the chair and if he got up it would make a "god awful" noise. NA-A said R3 did not like the alarms and said she was pretty sure he knew the camera was in his room and said he was always watching the camera. Regarding the alarms, NA-A stated R3 got aggressive when the alarms sounded and said they were loud and noisy. At 11:53 a.m., NA-B stated R3 had a stroke a few months prior and had weakens on one side. NA-B stated R3 could walk but needed a gait belt and had trouble gripping his walker. NA-B stated R3 had the video monitor and alarms because he would get up quickly and could fall. NA-B stated R3 did not like the alarms and said things like,	F 604		

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F 604	Continued From page 5 "shoot me in the f***ing head, the noise." At 12:05 p.m., the therapy manager (TM) stated therapy had recommended alarms and said she may have recommended the alarm in the dining room. The TM stated R3 had a history of a traumatic brain injury and a stroke and said he was impulsive and would stand up without anyone knowing. The TM stated therapy did not have a formal assessment for use of alarms. At 12:21 p.m., registered nurse (RN)-A stated R3 did not understand to ask for help and had poor left side vision so they decided to place alarms to give staff a heads up when he was ambulating. RN-A stated staff did not attempt other interventions prior to the alarms and said the family wanted the alarms for safety. RN-A stated R3 hated the alarms and did not understand the beeping and how to shut it up. RN-A said R3 would hear the alarm and sit back down or took off. At 1:05 p.m., R3 stated the alarms were annoying and said he was unable to turn it off. R3 said "if it were up to me, I would throw it away." At 1:13 p.m., Family member (FM)-A stated he was aware of the alarms and said the facility was worried R3 would fall. Regarding the camera, FM-A stated he did not remember the camera and said they must have wanted to keep an eye on him. FM-A said he was not aware R3 had been getting upset about the alarms and said having some privacy is something he respected and said he would like to see something that kept R3 safe but did not upset him. FM-A further stated he had not requested the alarms and said the facility felt like they needed them.	F 604		

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F 604	Continued From page 6 At approximately 2:00 p.m., the director of nursing (DON) and social worker (SW)-A were interviewed. SW-A stated the alarms were initiated after R3 had a stroke. SW-A stated R3 needed someone with him as he was unstable, jerky and ran into things. SW-A stated they felt alarms were the only way staff would know if R3 got up. The DON stated before initiating alarms they looked at whether a resident was physically able to get out of bed and if cognitively they knew where they were going. The DON stated from there they went on recommendations from therapy. SW-A stated they did not have a safety option for R3 and said it was either a one to one or he had to have an alarm. Facility policy Restraints, dated 8/2024, indicated residents had a right to be free from any physical of chemical restraint imposed for the purpose of discipline or convenience and not required to treat the resident's medical symptoms. The policy identified a restraint as any manual method of physical for mechanical device attached or adjacent to the resident body that restricted freedom of movement or normal access to one's body.	F 604		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 26, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: QN3211

Dear Administrator:

The above facility was surveyed on November 20, 2024 through November 20, 2024 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:

Annette Winters, Regional Operations Supervisor, Rapid Response
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 _____	11/20/2024

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) COMPLETE DATE
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 11/20/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed: H55801189C (MN00108011). As a result of the survey a licensing order was issued at 0510. 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 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		

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2 000	Continued From page 2 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		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to identify the use of restraints for 1 of 3 residents (R3) reviewed when the facility used multiple personal alarms and video cameras that restricted R3's movement and failed to attempt alternate interventions to prevent falls. Findings include: R3's Admission Record indicated he re-admitted to the facility 10/23/24, with diagnosis that included history of traumatic brain injury, cerebrovascular disease, depression, and insomnia. R3's significant change Minimum Data Set (MDS) identified moderately impaired cognition. The MDS indicated R3 required partial to moderate assistance for tilting and supervision/touching assistance for transfers and ambulation.	2 510	1. Regarding Resident R3 an alarm audit has been completed. It was determined as evidence by these audits that Resident R3 is cognitively unable to ask or comprehend the need for assistance from staff when it is required related to safety. The social worker and DON met with the guardian/POA for an optimal safety plan. The video surveillance camera was assessed and determined it was not a usable method for safety at this time. Alarm restraint entrapment evaluation has been updated. Comprehensive Medical - Necessity Evaluation by PCP completed to include Appropriate orders in relation to Alarm use. Care plan and education has been updated as well, and will continue to be assessed as changes occur. 2. Regarding all other residents; All residents that have the same or similar identifiers will have alarm use audits and	12/30/24

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2 510	Continued From page 3 R3's care plan dated 10/23/24, identified a self-care deficit related to traumatic brain injury, loss of fingers and thumb and Cerebral vascular accident. The care plan directed staff to provide contact guard assistance for toilet use, transfers and ambulation and indicated He moved very fast and became angry when staff stopped or interrupted. The care plan directed staff to stay by his right side and explain why they were assisting him. The care plan indicated R3 was at high risk for falls and indicated he required an alarm in bed, recliner chair and dining room chair due to inability to comprehend safe choices and ask for assistance. R3 facility progress notes indicated on 10/23/24 occupational therapy completed a room safety evaluation prior to his return and added chime alarms to the bed, recliner, and dining room chair that he sat in. R3 facility progress notes indicated on 10/23/24, R3 admitted back to the facility. R3 had left sided weakness and deficit to his left eye. R3 ambulated with walker and gait belt and required contact guard assistance with transfers and ambulation. Has alarms to his bed, recliner and dining room chair for safety related to cognition and did not always use his walker. R3 facility progress notes indicated on 10/30/24, R3 had a brief episode of yelling and swearing at staff. R3 at times got up and started walking without waiting for help. Reinforced that when alarm goes off it was to let staff know he may need some help. R3 seemed to startle easily. A Restraint/Entrapment Assessment dated 10/30/24, identified bed and chair alarms and	2 510	alarm restraint entrapments evaluations updated. 3. To assure this deficient practice does not occur in the future for the facility; The facility will update alarm restraint entrapments evaluations; to include a comprehensive assessment for the use of alarms/cameras. A review and update of the policy for restraints. All Staff will receive education with the review of this policy by 12/20/24. Audits for continued use of alarms will be reviewed on an admission, quarterly, yearly, or with a significant change in status. Education on the new process is to be provided to admitting staff and IDT Team with planned completion by 12/20/2024. 4. To assure this practice enhancement is sustainable and hardwired, Leadership (IE: Director of Nursing, LTC RN Manager, an IDT team member or designee) shall complete audits as follows: DON will audit all Admissions, quarterly, yearly, or with a significant change in status for the completion of this Evaluation as they occur in the next 2 months. Alarm Audits will be conducted by leadership to ensure alarms are not used for staff convenience as follows: Audit 3 times a week starting 12/09/24 for 1 week. Audit 1x weekly starting 12/16/24 for 2 weeks. Audit biweekly starting 12/23/24 for 1 month. Audit results will be reviewed weekly at ITD: High Risk Meetings and at QAPI meetings for the next 3 months, ending 3/1/2025.	

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2 510	Continued From page 4 indicated family wanted the alarms due to recent stroke that caused left side deficit and impaired vision to his left eye. The assessment indicated R3 was unable to make safe decision and required assistance with ambulation. The assessment indicated the alarms were not a restraint. The assessment did not address R3 reaction to the alarms and did not identify alternate interventions attempted prior to initiating the alarms. R3 facility progress notes indicated on 11/9/24, R3 has stood up the chair alarm went off. R3 sat back down but stated when staff approached, "I want to turn this damn thing off," pointing to the alarm. This happened three times. R3 facility progress notes indicated on 11/16/24, R3 was incontinent in the dining room and moved around on the alarm on the chair. Staff offered assistance and R3 was swinging his alarms and throwing his walker around. R3 yelled, those alarms were pissing him off and he was not going to put up with it. R3 facility progress notes indicated on 11/16/24, R3 continued to have behaviors regarding alarms. R3 got very angry that they continue to make noise and yelled at staff that they need to throw the "damn things" in the garbage. Stated they were too loud. During observation on 11/20/24 at 9:18 a.m. R3 was seated at a table in the dining room. R3 removed a pressure pad alarm from underneath him and set it on the table, then placed it on the floor. Staff responded to the alarm and placed it underneath him. During observation at 9:49 a.m., R3 was viewed	2 510		

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2 510	Continued From page 5 on a camera that was placed on a table in the hallway. R3 was lying in bed with the television remote control in his hand and kept looking toward the hallway. At 10:00 a.m. R3 sat up on the side of the bed and looked around. The alarm could be heard sounding and R3 laid back down on the bed. During interview on 11/20/24 at 11:43 a.m., nursing assistant (NA)-A stated the camera was used to monitor R3. NA-A stated R3 was unsteady and needed supervision and staff were unable to provide one to one supervision so the solution was to place a camera in his room. NA-A stated R3 also had alarms in his room that would sound if he got up. NA-A said usually when staff were busy, they place the camera in their pocket and a light would go on to signal if R3 got up. NA-A stated R3 had a pressure pad alarm under him in bed and the chair and if he got up it would make a "god awful" noise. NA-A said R3 did not like the alarms and said she was pretty sure he knew the camera was in his room and said he was always watching the camera. Regarding the alarms, NA-A stated R3 got aggressive when the alarms sounded and said they were loud and noisy. At 11:53 a.m., NA-B stated R3 had a stroke a few months prior and had weakens on one side. NA-B stated R3 could walk but needed a gait belt and had trouble gripping his walker. NA-B stated R3 had the video monitor and alarms because he would get up quickly and could fall. NA-B stated R3 did not like the alarms and said things like, "shoot me in the f***ing head, the noise." At 12:05 p.m., the therapy manager (TM) stated therapy had recommended alarms and said she may have recommended the alarm in the dining	2 510		

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2 510	Continued From page 6 room. The TM stated R3 had a history of a traumatic brain injury and a stroke and said he was impulsive and would stand up without anyone knowing. The TM stated therapy did not have a formal assessment for use of alarms. At 12:21 p.m., registered nurse (RN)-A stated R3 did not understand to ask for help and had poor left side vision so they decided to place alarms to give staff a heads up when he was ambulating. RN-A stated staff did not attempt other interventions prior to the alarms and said the family wanted the alarms for safety. RN-A stated R3 hated the alarms and did not understand the beeping and how to shut it up. RN-A said R3 would hear the alarm and sit back down or took off. At 1:05 p.m., R3 stated the alarms were annoying and said he was unable to turn it off. R3 said "if it were up to me, I would throw it away." At 1:13 p.m., Family member (FM)-A stated he was aware of the alarms and said the facility was worried R3 would fall. Regarding the camera, FM-A stated he did not remember the camera and said they must have wanted to keep an eye on him. FM-A said he was not aware R3 had been getting upset about the alarms and said having some privacy is something he respected and said he would like to see something that kept R3 safe but did not upset him. FM-A further stated he had not requested the alarms and said the facility felt like they needed them. At approximately 2:00 p.m., the director of nursing (DON) and social worker (SW)-A were interviewed. SW-A stated the alarms were initiated after R3 had a stroke. SW-A stated R3 needed someone with him as he was unstable,	2 510		

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2 510	Continued From page 7 jerky and ran into things. SW-A stated they felt alarms were the only way staff would know if R3 got up. The DON stated before initiating alarms they looked at whether a resident was physically able to get out of bed and if cognitively they knew where they were going. The DON stated from there they went on recommendations from therapy. SW-A stated they did not have a safety option for R3 and said it was either a one to one or he had to have an alarm. Facility policy Restraints, dated 8/2024, indicated residents had a right to be free from any physical of chemical restraint imposed for the purpose of discipline or convenience and not required to treat the resident's medical symptoms. The policy identified a restraint as any manual method of physical for mechanical device attached or adjacent to the resident body that restricted freedom of movement or normal access to one's body. SUGGESTED METHOD OF CORRECTION: The administrator, DON or designee could ensure restraint assessments were performed on all residents with alarms and/or cameras. Those assessments should occur upon admission, quarterly, yearly, with a significant change and periodically thereafter as needed. The facility could review policies and procedures, educate staff on changes, and perform audits periodically to ensure alarms are not used for staff convenience. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 510		