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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 00V7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00451

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245374**
2.STATE VENDOR OR MEDICAID NO.
(L2) **177550201**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKESIDE MEDICAL CENTER**
(L4) **129 EAST 6TH AVENUE**
(L5) **PINE CITY, MN** (L6) **55063**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/06/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **46** (L18)
13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susan Frericks, HPR SWS 10/20/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/23/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
10/06/2016
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5374

On October 6, 2016, the Department of Health completed a Post Certification Revisit (PCR) and on September 22, 2016 the Department of Public Safety completed a PCR to verify the facility achieved and maintained compliance with Federal participation requirements. We presumed based on the facility's plan of correction that the facility had corrected these deficiencies as of September 27, 2016. Based on our revisit we have deteremined the facility has corrected the deficiencies issued pursuant to the standard survey completed on August 187, 2016, effective September 27, 2016. Refer to the CMS 2567b forms for both health and life safety code for the results of the revisits.

Lakeside Medical Center is no longer designated as a Special Focus Facility (SFF)

Effective September 27, 2016 the facility is certified for 46 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245374

November 23, 2016

Mr. Max Blaufuss, Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, Minnesota 55063

Dear Mr. Blaufuss:

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

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

Effective September 27, 2016 the above facility is certified for:

46 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 46 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 20, 2016

Mr. Max Blaufuss, Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, Minnesota 55063

RE: Project Number S5374026

Dear Mr. Blaufuss:

On September 1, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 18, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On October 6, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 22, 2016, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 18, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 27, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 18, 2016, effective September 27, 2016 and therefore remedies outlined in our letter to you dated September 1, 2016, will not be imposed.

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.

Electronically delivered is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245374	A. Building B. Wing	10/6/2016

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4) LSC	Correction Completed 09/27/2016	ID Prefix F0226 Reg. # 483.13(c) LSC	Correction Completed 09/27/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) TA/mm	DATE 10/20/2016	SIGNATURE OF SURVEYOR 34983	DATE 10/06/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
8/18/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245374 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/22/2016 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0018	09/02/2016	LSC K0047	09/02/2016	LSC K0052	09/02/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0076	09/02/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[X]	TL/mm	10/20/2016	27200	09/22/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/16/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 20, 2016

Mr. Max Blaufuss, Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, Minnesota 55063

Re: Enclosed Reinspection Results - Project Number S5374026

Dear Mr. Blaufuss:

On October 6, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 18, 2016. At this time these correction orders were found corrected and are listed on the electronically delivered Revisit Report Form.

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

cc: Licensing and Certification File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00451 (Y1)	A. Building B. Wing (Y2)	10/6/2016 (Y3)

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

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 21990 Reg. # MN St. Statute 626.557 Subd. 4 LSC	Correction Completed 09/27/2016	ID Prefix 21995 Reg. # MN St. Statute 626.557 Subd. 4a LSC	Correction Completed 09/27/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	**REVIEWED BY (INITIALS)** TA/mm	**DATE** 10/20/2016	**SIGNATURE OF SURVEYOR** 34983	**DATE** 10/06/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 8/18/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 00V7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00451

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245374**
2.STATE VENDOR OR MEDICAID NO.
(L2) **177550201**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKESIDE MEDICAL CENTER**
(L4) **129 EAST 6TH AVENUE**
(L5) **PINE CITY, MN** (L6) **55063**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/18/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **46** (L18)
13.Total Certified Beds **46** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	46			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NEII 09/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/05/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5374

Lakeside Medical Center is designated as a Special Focus Facility (SFF)

On August 18, 2016 a recertification survey was completed. The most serious deficiencies were cited at a S/S level of E. The facility has been given an opportunity to correct before remedies would be imposed. Refer to the CMS 2567 forms for both health and life safety code along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

H Complaint H5374013 was investigated and not substantiated.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 1, 2016

Mr. Max Blaufuss, Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, Minnesota 55063

RE: Project Number S5374026, H5374013

Dear Mr. Blaufuss:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On August 18, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the August 18, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5374013. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the August 18, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5374013 that was found to be unsubstantiated.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 27, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will

recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by November 18, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 18, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245374	A. BUILDING _____ B. WING _____	08/18/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Lakeside Medical Center is a Special Focus Facility (SFF) and a certification survey was conducted on August 15- 18, 2016. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. H Complaint H5374013 was investigated and not substantiated.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations	F 225	TA 9/7/16	9/27/16

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

Electronically Signed | 09/07/2016

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 225	Continued From page 1 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure alleged violations of mistreatment were identified and immediately reported to the administrator and state agency and investigated regarding scolding and rude treatment of 1 of 4 residents (R31) reviewed for abuse. Findings include: R31's Admission Record printed 8/18/16, indicated R31 diagnoses included chronic pain and chronic obstructive pulmonary disease (breathing difficulties).	F 225	It is policy of Lakeside Medical Center (LSMC) not to employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities.	

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F 225	Continued From page 2 R31's quarterly Minimum Data Set (MDS) assessment dated 6/26/16, indicated R31 was cognitively intact, was understood and understood others, and had no delirium, mood or behavior problems. R31's MDS further indicated R31 required extensive assistance of 2 staff for transfers, dressing, and toilet use, and required extensive assist of one staff for bed mobility, locomotion of the wheelchair, and personal hygiene. The MDS indicated R31 was frequently incontinent of bladder and occasionally incontinent of bowel, and had almost constant pain rated at 8 out of 10. R31's care plan revised 10/7/15, indicated R31 had minor short term memory deficits, though was oriented to person, place, room location, and staff. R31's care plan further indicated R31 was able to voice wants and needs, speech was clear and understandable, was independent with decision making for daily needs, and safety awareness was appropriate. R31's Social Service Assessment (SSA) dated 8/15/16, indicated R31 was oriented to person, place, time and events, memory was intact, and decision making was independent. The SSA further indicated R31 was able to verbalize all needs, her mood was appropriate to circumstances, and had no behaviors. On 8/15/16, at 6:39 p.m. R31 stated she had experienced some problems with a staff member who had been verbally disrespectful to her. R31 did not want to expand on that comment at that time, but stated the staff member had improved earlier during the present day.	F 225	The facility ensures that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are immediately reported to the administrator of the facility and the state agency in accordance to state law via facility policy and procedure. The facility provides evidence that all alleged violations are thoroughly investigated and takes steps to prevent further potential abuse while the investigation is in progress. The results of the investigation are reported to the administrator and the state agency within 5 working days of the incident. If the alleged violation is verified, appropriate corrective action is taken. The Vulnerable Adult Policy was reviewed and updated. The facility has posted the new updated policy and will provide education to all staff on 9/14/16. Education will include how to identify various forms of mistreatment and proper actions to take to report alleged mistreatment. LSMC conducts screening, including criminal background check upon hire, rehire or greater than 120 days absence from the facility to ensure the facility employs qualified staff. New staff will be trained on proper identification and reporting of alleged mistreatment of residents. R31 was assessed on 8/9/16 by the DON, following her allegation of mistreatment by NA-B. NA-B was disciplined and reeducated on appropriate behavior and prevention of mistreatment of vulnerable adults. R31 was re-interviewed by DON	

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F 225	Continued From page 3 On 8/16/16, at 11:37 a.m. R31 stated nursing assistant (NA-B) had been very rough previously in verbal ways and in actions, so much that R31 was going to ask her daughter to find another place for her, and said she couldn't take it if she kept up like that. R31 stated she had reported it to the director of nursing (DON), who had told her she would talk to NA-B. R31 reported that NA-B was on her phone while taking her blood pressure. NA-B had thrown R31's sweater in the chair, after getting R31 into bed, and abruptly threw the covers up over her and asked her if she was "warm now" in a rude manner. R31 stated she had reported it to the DON last week. The facility's grievance log indicated R31 made a report involving patient cares on 8/15/16. The Record of Grievance for R31's concerns was not written and reviewed until 8/15/16. On 8/16/16, at 5:55 p.m. the DON verified that R31 had spoken to her and located their conversation in a notebook. The DON stated R31 reported she had not been satisfied with the cares provided by NA-B and said NA-B was on her cell phone while taking her vital signs, acted like she didn't care, and felt she was lazy. R31 had reported that she had been scolded for being incontinent of bowel. The DON stated she checks with the resident to make sure she feels safe and that it is not abuse. The DON had told R31 she would talk to the staff member. The DON stated this event happened on 7/15/16. The DON's notebook notes dated 8/9/16, indicated there was a report by R31 which indicated a staff was on the telephone during taking vitals, acted like she didn't care, used a	F 225	on 8/16/16, and reported that no further incidents have occurred and that NA-B performance had "shocking" improvement. Residents on the unit were also screened for potential mistreatment on 8/17/16. No further concerns were received since NA-B was reeducated. The facility has created an audit to ensure all allegations of mistreatment are handled in accordance with the policy. Sources for concerns of mistreatment will include review of the 24 hour report sheets, nurses' notes, and incident reports. The DON/ SSD or designee will audit all concerns weekly x4, then up to 4 concerns weekly x4 weeks and then up to 2 residents weekly x 4 weeks or until 100% compliance is achieved. Results will be audited by the DON or designee and reviewed at the quarterly QAPI meeting. The administrator will monitor the results of the audits and overall compliance.	

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F 225	Continued From page 4	F 225		

tone of voice that was not respectful, didn't respect belongings, and "Gave her heck" for being incontinent of bowel. The notes indicated R31 did not want the staff member and would look for a different home.

R31's progress notes lacked documentation of R31's grievance about a specific staff member.

On 8/17/16, at 2:15 p.m. the DON stated a grievance had been started and she had followed up with R31, who had reported that NA-B had improved and was very nice. The DON stated she reports things according to the vulnerable adult policy and reports immediately to the state agency. The DON verified she had not reported the scolding and degrading, as she was following up on another grievance and was in the middle of it, and stated R31 was not feeling injured by it. The DON stated she would leave it up to the resident, but stated she could not recall if she had asked R31 how she had felt at the time of the incident. The DON stated she would report it if the resident was intentionally verbally abused, and would be by the intent. The DON stated R31 was cognitively intact and was able to tell her how she felt, so did not report it. In addition, the DON stated any one can fill out a grievance and all incidents are discussed at the morning meeting, including grievances. The DON stated that maybe it wasn't reviewed as potential abuse, but it would be reported if it was. The DON stated in order to protect the resident during the investigation, they would remove the staff member from the schedule, until follow up was done, and staff would be retrained.

On 8/17/16, at 2:31 p.m. social service designee (SSD) stated grievances would be dispensed to

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F 225	Continued From page 5	F 225		

the department that it was pertaining to, then discuss it at the interdisciplinary team (IDT) meeting when she got it back. The SSD stated abuse, bruises or a resident stating roughness had occurred would be reported. The SSD stated she would ask the resident to define rough. Internally it would be reported to the administrator or the DON. The DON and SSD stated they would report to the state agency within 24 hours. The SSD verified she did not ask how R31 felt.

On 8/17/16, at 3:02 p.m. R31 verified NA-B scolded her for being incontinent in her bed. R31 stated she had turned on her call light and waited a long time. R31 stated NA-B came and asked her why she did that (was incontinent in her bed). R31 stated if it had been a different staff member, she would not have been scolded. R31 stated NA-B had gotten better, but that she still did not trust her and did not know if she felt safe with her.

On 8/18/16, at 4:03 p.m. NA-B was working on the medication cart at the end of the hallway near R31's room. NA-B was passing medications by herself. No other staff were in the area at that time.

On 8/18/16, at 4:25 p.m. the DON stated NA-B was in training as a trained medication assistant and was working under supervision of a nurse. The DON verified NA-B was working in R31's hallway. The DON stated she had followed up with R31, who said she was fine. The DON also indicated she had followed up today with R31 regarding what she had meant by getting "heck" for being incontinent.

The facility was unable to provide a report to the

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F 225	Continued From page 6 state agency or to the administrator regarding the incident involving R31. The facility policy and procedure for Vulnerable Adult Policy reviewed 8/27/15, defined verbal abuse as, "The use of oral, written or gestured language that willfully includes disparaging and derogatory, humiliating, harassing or threatening terms to residents or their families or within their hearing distance, regardless of age, ability to comprehend or disability." The policy and procedure directed alleged or suspected cases of mistreatment and abuse be reported immediately to the state agency and the administrator. In addition, the policy directed that upon receiving the complaint, the administrator, DON and social services would investigate, complete witness statements, interview all parties involved and remove the implicated staff member from the resident care area immediately.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure implementation of written policies and procedures related to identification and immediate reporting to the state agency regarding potential abuse for 1 of 4 residents (R31) reviewed for abuse.	F 226	It is policy of Lakeside Medical Center (LSMC) not to employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the state nurse aide registry	9/27/16

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F 226	Continued From page 7 Findings include: The facility policy and procedure for Vulnerable Adult Policy reviewed 8/27/15, defined verbal abuse as, "The use of oral, written or gestured language that willfully includes disparaging and derogatory, humiliating, harassing or threatening terms to residents or their families or within their hearing distance, regardless of age, ability to comprehend or disability." The policy and procedure directed alleged or suspected cases of mistreatment and abuse be reported immediately to the state agency and the administrator. In addition, the policy directed that upon receiving the complaint, the administrator, DON and social services would investigate, complete witness statements, interview all parties involved and remove the implicated staff member from the resident care area immediately. On 8/15/16, at 6:39 p.m. R31 stated she had experienced some problems with a staff member who had been verbally disrespectful to her. R31 did not want to expand on that comment at that time, but stated the staff member had improved earlier during the present day. The facility's grievance log indicated R31 made a report involving patient cares on 8/15/16. On 8/16/16, at 11:37 a.m. R31 stated nursing assistant NA-B had been very rough previously in verbal ways and in actions, so much that R31 was going to ask her daughter to find another place for her and said she couldn't take it if she kept up like that. R31 stated she had reported it to the director of nursing (DON), who had told her she would talk to NA-B. R31 reported that NA-B	F 226	concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the state nurse aide registry or licensing authorities. The facility ensures that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are immediately reported to the administrator of the facility and the state agency in accordance to state law via facility policy and procedure. The facility provides evidence that all alleged violations are thoroughly investigated and takes steps to prevent further potential abuse while the investigation is in progress. The results of the investigation are reported to the administrator and the state agency within 5 working days of the incident. If the alleged violation is verified, appropriate corrective action is taken. The Vulnerable Adult Policy was reviewed and updated. The facility has posted the new updated policy and will provide education to all staff on 9/14/16. Education will include how to identify various forms of mistreatment and proper actions to take to report alleged mistreatment. LSMC conducts screening, including criminal background check upon hire, rehire or greater than 120 days absence from the facility to ensure the facility employs qualified staff. New staff will be trained on proper identification and	

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F 226	Continued From page 8 was on her phone while taking her blood pressure. NA-B had thrown R31's sweater in the chair, after getting R31 into bed, and abruptly threw the covers up over her and asked her if she was "warm now" in a rude manner. R31 stated she had reported it to the DON last week. The Record of Grievance for R31's concerns was not written and reviewed until 8/15/16. On 8/16/16, at 5:55 p.m. the DON verified that R31 had spoken to her and located their conversation in a notebook. The DON stated R31 reported she had not been satisfied with the cares provided by NA-B and said NA-B was on her cell phone while taking her vital signs, acted like she didn't care, and felt she was lazy. R31 had reported that she had been scolded for being incontinent of bowel. The DON stated she checks with the resident to make sure they feel safe and that it is not abuse. The DON had told R31 she would talk to the staff member. The DON stated this even happened on 7/15/16. The DON's notebook notes dated 8/9/16, indicated there was a report by R31 which indicated a staff was on the telephone during taking vitals, acted like she didn't care, used a tone of voice that was not respectful, didn't respect belongings, and "Gave her heck" for being incontinent of bowel. The notes indicated R31 did not want the staff member and would look for a different home. On 8/17/16, at 2:15 p.m. the DON stated a grievance had been started and she had followed up with R31, who had reported that NA-B had improved and was very nice. DON stated she reports things according to the vulnerable adult	F 226	reporting of alleged mistreatment of residents. R31 was assessed on 8/9/16 by the DON, following her allegation of mistreatment by NA-B. NA-B was disciplined and reeducated on appropriate behavior and prevention of mistreatment of vulnerable adults. R31 was re-interviewed by DON on 8/16/16, and reported that no further incidents have occurred and that NA-B performance had "shocking" improvement. Residents on the unit were also screened for potential mistreatment on 8/17/16. No further concerns were received since NA-B was reeducated. The facility has created an audit to ensure all allegations of mistreatment are handled in accordance with the policy. Sources for concerns of mistreatment will include review of the 24 hour report sheets, nurses' notes, and incident reports. The DON/ SSD or designee will audit all concerns weekly x4, then up to 4 concerns weekly x4 weeks and then up to 2 residents weekly x 4 weeks or until 100% compliance is achieved. Results will be audited by the DON or designee and reviewed at the quarterly QAPI meeting. The administrator will monitor the results of the audits and overall compliance.	

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F 226	Continued From page 9	F 226		

policy and reports immediately. The DON verified she had not reported the scolding and degrading, as she was following up on another grievance and was in the middle of it, and stated R31 was not feeling injured by it. The DON stated she would leave it up to the resident, but stated she could not recall if she had asked R31 how she had felt at the time of the incident. The DON stated she would report it if the resident was intentionally verbally abused, and would be by the intent. The DON stated R31 was cognitively intact and was able to tell her how she felt, so did not report it. In addition, the DON stated any one can fill out a grievance and all incidents are discussed at the morning meeting, including grievances. The DON stated that maybe it wasn't reviewed as potential abuse, but it would be reported if it was. The DON stated in order to protect the resident during the investigation, they would remove the staff member from the schedule, until follow up was done, and staff would be retrained.

On 8/17/16, at 2:31 p.m. social service designee (SSD) stated grievances would be dispensed to the department that it was pertaining to, then discussed at the interdisciplinary team (IDT) meeting when she got it back. The SSD stated abuse, bruises or a resident saying roughness occurred would be reported. The SSD stated she would ask the resident to define rough. Internally it would be reported to the administrator or the DON. The DON and SSD stated they would report within 24 hours. The SSD verified she did not ask how R31 felt.

On 8/17/16, at 3:02 p.m. R31 verified NA-B scolded her for being incontinent in her bed. R31 stated she had turned on her call light and waited

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	245374	A. BUILDING _____ B. WING _____	08/18/2016

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

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F 226	Continued From page 10 a long time. R31 stated NA-B came and asked her why she was incontinent in her bed. R31 stated if it had been a different staff member, she would not have been scolded. R31 stated NA-B had gotten better, but that she still did not trust her and did not know if she felt safe with her. On 8/18/16, at 4:03 p.m. NA-B was working on the medication cart at the end of the hallway near R31's room. NA-B was passing medications by herself. No other staff were in the area at that time. On 8/18/16, at 4:25 p.m. the DON stated NA-B was in training as a trained medication assistant and was working under supervision of a nurse. The DON verified she was working in R31's hallway. The DON stated she had followed up with R31, who said she was fine. The DON also indicated She had followed up today with R31 regarding what she had meant by getting "heck" for being incontinent. The facility was unable to provide a report to the state agency or to the administrator regarding the incident involving R31.	F 226		

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	245374	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY Building 01 - Main Building: THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Lakeside Medical Center C & NC was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/02/2016

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

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K 000	Continued From page 1 St. Paul, MN 55101 Or by e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lakeside Medical Center C & NC is a 1-story building with a full basement. The original building was constructed in 1966 with an addition constructed in 1971. The 1966 building is of type II(111) construction and the 1971 building is type II(111) construction. Therefore, the nursing home was inspected as one building. The facility has a small hospital and clinic, attached, and they are properly separated from the nursing home. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 46 beds	K 000		

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K 000	Continued From page 2 and had a census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT met.	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had 1 of several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.3.6.3.2. This deficient practice could affect 12 of 35 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 10:00 AM to 2:00 PM on 08/16/2016, observations revealed that there was	K 018	All door stops were removed from facility rooms as of 8-16-17. Door stop on glass door of 2C hallway was removed 8-17-16. Staff communication out 9-2-16 about use of door stops in doors. Jaime Burg EVS is responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	9/2/16

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K 018	Continued From page 3 an unapproved door hold open devise (wooden wedge) holding the corridor door to resident room 270 in the open position This deficient condition was verified by a Maintenance Supervisor.	K 018		
K 047 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide 1 of several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.5.2. The deficient practice could affect residents, as well as an undetermined number of staff, and visitors from the lack of properly identified means of egress in the event of and emergency. Findings include: On facility tour between 10:00 AM to 2:00 PM on 08/16/2016, it was observed that the exit sign located on the 1st floor at the stairwell by room 172 is not illuminated due to a burnt out interior light bulb. This deficient condition was verified by a Maintenance Supervisor.	K 047	Exit light bulbs were replaced as of 8-17-16. Staff will check bulbs while checking fire extinguishers monthly to prevent future outages. Jaime Burg EVS is responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	9/2/16
K 052	NFPA 101 LIFE SAFETY CODE STANDARD	K 052		9/2/16

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K 052 SS=E	Continued From page 4 A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 2-3.4.5.1.2, 2-3.5.1. These deficient practices could adversely affect the functioning of the fire alarm system that could delay the timely notification and emergency actions for the facility thus negatively affecting 12 of 35 residents, as well as an undetermined number of staff, and visitors Findings include: On facility tour between 10:00 AM to 2:00 PM on 08/16/2016, observation revealed, that the smoke detector located on the 2nd floor outside of room 283 was installed within 36 inches of a HVAC vent diffuser This deficient condition was verified by a Maintenance Supervisor.	K 052	Ceiling tile was moved on 8-26-16 so there is at least 36" between detector and vent. Check of building was also done to ensure no further issues with smoke detectors and vents were found. Jaime Burg EVS is responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	
K 076 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.	K 076		9/2/16

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K 076	Continued From page 5 (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observations and staff interview, that the oxygen storage room was not maintained in accordance with NFPA 99 Standards for Health Care Facilities (1999 edition). This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This deficient practice could affect 10 of 35 residents, as well as an undetermined number of staff, and visitors in the event of an emergency. Findings include: On facility tour between 10:00 AM to 2:00 PM on 08/16/2016, observations revealed the following deficient conditions affecting the oxygen storage room 213 on the 2nd floor of the facility: 1. There are multiple mini portable and E-size oxygen cylinders that are not being secured from tipping over due to the current chain that is loosely wrapped around the cylinders, and 2. The door to the oxygen storage room did not completely close and positively latch into the door frame. This deficient condition was verified by a Maintenance Supervisor.	K 076	Oxygen tanks not in use have been removed from facility as of 9-2-16. Door to oxygen room (213-D) was fixed on 8-18-16 so that door shuts properly on its own. Jaime Burg EVS will be responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 1, 2016

Mr. Max Blaufuss, Administrator
Lakeside Medical Center
129 East 6th Avenue
Pine City, Minnesota 55063

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5374026, H5374013

Dear Mr. Blaufuss:

The above facility was surveyed on August 15, 2016 through August 18, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5374013. that was found to be unsubstantiated. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule 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 DEFICIENCIESONLY. 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 Teresa Ament at (218) 302-6151 or email: teresa.ament@state.mn.us**.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00451	A. BUILDING: _____ B. WING _____	08/18/2016

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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: The Lakeside Medical Center is a Special Focus Facility (SFF) and a certification survey was conducted on August 15- 18, 2016. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health	2 000	TA 9/7/16	

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

Electronically Signed | 09/07/16