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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: B3WW
Facility ID: 00332

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245580**
2. STATE VENDOR OR MEDICAID NO. (L2) **911243000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKEWOOD CARE CENTER**
(L4) **600 MAIN AVENUE SOUTH**
(L5) **BAUDETTE, MN** (L6) **56623**

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 **05/18/2021** (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 **32** (L18)
13.Total Certified Beds **32** (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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 32 | | | |
| (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):

17. SURVEYOR SIGNATURE Date :
Jennifer Bahr, Unit Supervisor 06/17/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 06/17/2021 (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
**10/01/1991**
(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
**05/27/2021**
(L33)

DETERMINATION APPROVAL

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

Electronically delivered
June 17, 2021

CMS Certification Number (CCN): 245580

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

Dear Administrator:

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 May 18, 2021 the above facility is certified for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

*P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s*

Electronically Delivered
June 17, 2021

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

RE: CCN: 245580
Cycle Start Date: April 15, 2021

Dear Administrator:

On May 18, 2021, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

## PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: B3WW
Facility ID: 00332

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245580**

2. STATE VENDOR OR MEDICAID NO. (L2) **911243000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKEWOOD CARE CENTER**
(L4) **600 MAIN AVENUE SOUTH**
(L5) **BAUDETTE, MN** (L6) **56623**

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 **04/15/2021** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **32** (L18)

13.Total Certified Beds **32** (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 |
|---|---|---|---|---|
| | 32 | | | |
| (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):

17. SURVEYOR SIGNATURE Date :
Patricia Winger HFE - NE II 05/25/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 05/26/2021 (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 **10/01/1991** (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

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

Electronically delivered
April 29, 2021

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

RE: CCN: 245580
Cycle Start Date: April 15, 2021

Dear Administrator:

On April 15, 2021, a 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.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

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

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

DEPARTMENT CONTACT

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 15, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by October 15, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245580 | A. BUILDING ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| E 000 | Initial Comments<br><br>A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted from 4/12/21 through 4/15/19, during a recertification survey.<br><br>The facility was in compliance with the Appendix Z Emergency Preparedness Requirements. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 4/12/21, through 4/15/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were found to be SUBSTANTIATED:<br>H5580008C (MN64597)<br>H5580010C (MN57495)<br>H5580011C (MN53740)<br><br>However, no deficiencies were cited related to the complaints due to actions taken by the facility prior to investigation.<br><br>The complaint H5580009C (MN59433) was found to be UNSUBSTANTIATED<br><br>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. | F 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 05/06/2021 |

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

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | Continued From page 1<br><br>Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 676 SS=D | Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii)<br><br>§483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that:<br><br>§483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ...<br><br>§483.24(b) Activities of daily living.<br>The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:<br><br>§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,<br><br>§483.24(b)(2) Mobility-transfer and ambulation, including walking,<br><br>§483.24(b)(3) Elimination-toileting, | F 676 | | 5/12/21 |

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 676 | Continued From page 2<br>§483.24(b)(4) Dining-eating, including meals and snacks,<br><br>§483.24(b)(5) Communication, including<br>(i) Speech,<br>(ii) Language,<br>(iii) Other functional communication systems.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure a resident was reassessed/referrals were completed to ensure appropriate interventions were initiated for a decline in activities of daily living for 1 of 1 resident (R4) reviewed for a decline in ADL's.<br><br>Findings include:<br><br>R4's quarterly Minimum Data set (MDS) dated 12/31/20, indicated R4 required extensive assistance from one staff for bed mobility, transfers, toileting and ambulation. R4's significant change MDS dated 3/24/21, identified R4 had moderate cognitive impairment and required total assistance from two staff for bed mobility, transfers and toileting and total assistance from one staff to eat and complete personal hygiene. The MDS indicated R4 did not ambulate.<br><br>R4's ADL care area assessment (CAA) dated 3/29/21, triggered due to total dependence on staff for bed mobility, transfer, locomotion, eating, toileting and personal hygiene needs. The CAA had multiple system pre-populated checks for possible underlying problems indicated delirium, changing cognitive status, communications and mood decline. Risk factor due to decline indicated incontinence and depression. Input from resident | F 676 | Lakewood Care Center does provide ADL services to its residents in accordance with their identified needs. The facility does recognize that during its annual survey 1 resident; resident # 4 was identified to have returned from the hospital post CVA and the reassessment/referrals were not completed to ensure appropriate interventions were initiated to prevent a decline in activities of daily living.<br>1.Regarding resident #4 the facility has completed review of the resident�s medical record and has completed a PT evaluation on 5/4/21 to determine the resident�s status and possible needs to assure the resident is receiving the best ADL cares to maintain or obtain the resident�s highest practicable level. The medical record was revised to reflect this evaluation.<br>2.Regarding all other residents who reside in the facility who might be affected by this deficient practice; the facility has reviewed their medical records to assure that they are receiving the ADL support to maintain their best level of abilities. Their | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245580 | A. BUILDING ______<br>B. WING ______ | C<br>04/15/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKEWOOD CARE CENTER** | **600 MAIN AVENUE SOUTH**<br>**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 676 | Continued From page 3<br>and/or representative was not obtained. Care plan consideration included maintain current level of function and minimize risk. Referral to another discipline indicated "no". The problem/need indicated "residents overall health decline" due to stroke, and required total care, without further analysis or interventions identified.<br><br>R4's care plan dated 3/31/21, identified R4 had a self care deficit related to a history of a cerebral vascular accident (stroke). The care plan directed staff to provide extensive assistance with transfers using a mechanical lift. The care plan indicated R4 was independent with bed mobility and did not participate in hygiene related to toileting.<br><br>R4's undated nursing assistant (NA) care sheet Lakewood Care Center Group 1, indicated "resident unable to walk - if begins to attempt will need PT (physical therapy) consult.<br><br>During observation on 4/12/21, at 2:39 p.m. R4 was lying in bed with his eyes closed. R4's bed was lowered all the way to the floor and had a full size mattresses on each side. At 5:04 p.m. R4 was seated in a wheel chair next to the medication cart and was asking what was for dinner. At 7:04 p.m. R4 was back in bed.<br><br>On 4/13/21, at 10:43 a.m. R4 was in bed. At 11:40 a.m. R4 remained in bed while other residents on the unit ate lunch. At 1:04 p.m. R4 remained in bed.<br><br>R4's progress note(s) identified the following:<br><br>- 2/12/21, R4 returned from the hospital, condition indicated returned to baseline. | F 676 | medical records have been adjusted as necessary. The facility reviewed its communication/ collaboration processes with other supporting entities and reviewed the LPN/CNA process (CNA group sheets) for identifying resident needs and changes, and their responsibility (LPNS and CNAs) to collaborate during the shift and respond or report the change to the Case Manager for follow through.<br>3.To assure that this deficient practice does not occur in the future the facility has completed training for those staff member responsible to this regulatory tag. The training includes MDS review for how to follow through on CAA triggers for possible underlying problems, training regarding communication with other supporting entities such as Therapies, training of the floor staff (LPNs/CNAs) who care for the residents to assure they understand changes and how to recognize them and what follow through is needed. Training completed 05-12-2021.<br>4.To assure this practice enhancement is sustainable and hardwired the nursing leadership (Case Managers and Director of Nursing) shall complete audits as follows:<br>a.DON to audit all hospital returns and all new admissions as they occur for the next 3 months.<br>b.DON to audit all significant changes as they occur for the next 3 | |

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 676 | Continued From page 4<br><br>- 2/14/21, R4 requested to use the bathroom twice. Staff assisted both times using walker. R4 stood and transferred well then assisted with walker and gait belt to bed.<br><br>- 2/16/21, R4 has had a progressive decline over the past couple of months. Some days not cooperative or comprehending, other days compliant with contact guard assist and pivot transfers successful.<br><br>- 2/27/21, R4 continued to have no additional changes since previous review. Baseline continued to fluctuate with left sided weakness noted. One or two days per week R4 was able to complete pivot transfer to chair next to bed and other times required mechanical lift.<br><br>- 3/16/21, R4 required the use of a mechanical lift to get out of bed.<br><br>- 3/20/21, R4 continued to progress to the use of a mechanical lift with all transfers over the past couple of weeks.<br><br>- 3/24/21, Significant change assessment. R4 had a decline in his ADL status in the last couple of weeks and was requiring more help with ADL's.<br><br>- 4/6/21, Care conference with no specified nursing concerns.<br><br>- 4/13/21, R4's transfer status had progressed to full mechanical lift for transfers. Care plan was updated to total assistance from two staff for transfers. Previously stated contact guard assistance from one to two staff using a gait belt and walker. If R4 were to attempt to be mobile | F 676 | months.<br>c.To assure the daily care process is being completed and responded to timely- Case Managers will completed audits daily for the first 2 weeks, then twice a week for 2 weeks, then weekly for the next 2 weeks and then every other week for the next month.<br>d.These audit results will be reviewed at the quarterly QA&A meetings.<br>5.Completion date: 05-12-2021 | |

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 676 | Continued From page 5 | F 676 | | |

with attempts to walk a PT evaluation would be appropriate.

On 4/13/21, at 3:33 p.m.. licensed practical nurse (LPN)-A stated R4 had declined in ability, R4 did not want to get out of bed, and slept most of the time. LPN-A stated when R4 was up he was unable to feed himself. R4 had not been receiving therapy services but did not know why.

At 3:36 p.m. registered nurse (RN)-A stated R4 had been hospitalized in February 2021, the hospital wanted to send him to either Fargo or Grand Forks but family had declined. RN-A stated when R4 returned from the hospital he was at his baseline for ADL's but had since had a significant change in his abilities. RN-A stated R4 had not been referred to therapy and was not sure at what point therapy should have been recommended. Further, RN-A had been completing the MDS assessments but stated there were some "pieces missing" related to the CAA's. She was still learning and was not really sure what the CAA entailed or what it was used for.

At 3:48 p.m. the director of nursing (DON) stated the significant change in status should have had been discussed in the interdisciplinary team (IDT) meeting. The DON stated R4's need for a therapy evaluation should have been discussed and documented by RN-A, and should have been referred to therapy for an evaluation.

On 4/14/21, at 1:06 p.m. physical therapist (PT)-A stated the IDT had a meeting weekly in which they discussed anyone who had returned from the hospital and discussed residents status. PT-A stated residents who needed a therapy evaluation would have been addressed at that time. PT-A

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 676 | Continued From page 6 | F 676 | | |

stated following R4's hospitalization he had been able to complete a stand pivot transfer. A therapy referral was not generated because R4 was not walking and stated, "he has to be moving". PT- A stated in R4's case a therapy evaluation had not been done following the significant change because he was not ambulatory. PT-A stated "if he was still walking....... but he is at the highest level of care." Further, PT-A did not screen R4 for potential treatment related to the decline in other ADL abilities.

A facility Rehab Services policy dated 5/3/10, indicated physical medicine programs involved intense, comprehensive and educational and physical therapeutic procedures and exercised and should be justified in terms of their contribution to returning the injured patient to their previous functional status. The policy indicated an initial evaluation to be completed; however, did not identify when therapy would be appropriate during the course of a residents long term stay at the facility.

The Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1 dated 11/19, identified "The CAA process provides guidance on how to focus on key issues identified during a comprehensive MDS assessment and directs facility staff and health professionals to evaluate triggered care areas. After obtaining input from the resident, the resident's family, significant other, guardian, or legally authorized representative, the IDT decides whether or not to develop a care plan for triggered care areas. the CAA process provides for further assessment of the triggered areas by guiding staff to look for causal or confounding

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 676 | Continued From page 7 factors, some of which may be reversible. It is important that the CAA documentation include the causal or unique risk factors for decline or lack of improvement. The plan of care then addresses these factors, with the goal of promoting the resident ' s highest practicable level of functioning: (1) improvement where possible, or (2) maintenance and prevention of avoidable declines. Documentation should support your decision making regarding whether to proceed with a care plan for a triggered CAA and the type(s) of care plan interventions that are appropriate for a particular resident. Documentation may appear anywhere in the clinical record, e.g., progress notes, consults, flowsheets, etc." | F 676 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide regular monitoring of ongoing skin conditions to ensure progress in healing for 1 of 1 residents (R75) reviewed for non- pressure related skin concerns.<br><br>Findings include: | F 684 | Lakewood Care Center does have processes in place to provide regular monitoring of ongoing skin conditions to ensure progress in healing said skin conditions. The facility does recognize that during its annual survey 1 resident; resident #75 did have assessments and | 5/12/21 |

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 8<br>R75's quarterly Minimum Data Set (MDS) dated 3/3/21, indicated R75 had moderate cognitive impairment and was independent with activities of daily living; however, required assistance with bathing. The MDS identified R75 was not at risk for pressure ulcers, had no venous or arterial ulcers, no open lesions including cancer lesions and did not receive any treatments to skin including his feet.<br><br>R75's care plan dated 3/11/21, identified a skin tear related to fragile skin and impaired skin integrity with a growth on his posterior scalp related to cancer. The care plan further identified a history of a left heel fissure as well as dry, cracked heels and directed staff to apply ointment to both heels as needed and treatment and dressing change of "location" per provider direction.<br><br>R75's Treatment Administration Record (TAR) dated April 2021, indicated the following orders:<br><br>- Dressing to left pinky toe and left foot sole, planter wart location weekly and as needed with a start date of 2/18/21.<br><br>- Apply lotion topically to both heels daily for dry, cracked heels with a start date of 3/18/21.<br><br>R75's physician visit note dated 3/16/21, indicated R75 was seen related to skin concerns on R75's right thumb, left foot and older skin tears on the left arm. R75 reported pain on the left 5th toe and some pain with pressure to the ball of his foot. The physical exam indicated: Bilateral feet with very dry and thick peeling skin on the heels. Bilateral heels are boggy, 1.5 centimeter (cm) plantar wart on ball of left foot, 1 cm corn on left | F 684 | care planning completed to identify the residents skin needs but they were inconsistent and there was lack of follow through on the skin concerns.<br>1.Regarding resident # 75; the resident has had skin re-assessed by the Case Manager, and was seen by the Provider on 5/4/21 for his dry skin, callouses on the ball of the foot and left fifth toe. Provider states heels are not boggy, it is the sloughing of callouses that creates that appearance, further discussion with Provider indicates resident can benefit from callouses being assessed by Podiatrist.<br>New podiatrist to be on site in a couple of weeks and appointment will be made at that time. Lotion to be applied to feet, dry skin and callouses BID and prn.Resident has had his shoes assessed for fit concerns related to corn. His medical record has been updated to reflect the changes in care needs.<br>2.Regarding all other residents who reside in the facility who might be affected by this deficient practice, their medical records have been reviewed and revised, as necessary.The process for identifying and on-going monitoring of skin care needs has been reviewed and revised to better enhance this process to better meet the needs of the residents. The facility will be moving skin concerns or condition monitoring from the weekly PPS meeting | |

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 9<br>fifth toe.<br><br>R75's progress note dated 3/16/21, indicated R75 was seen in clinic for plantar wart on left foot, right thumb growth and skin tear follow up.<br><br>R75's medical record lacked evidence R75's skin and feet were assessed.<br><br>On 4/14/21, at 8:22 a.m. registered nurse (RN)-A stated R75 had fissures on his heels and a plantar wart on the sole of his foot. RN-A stated R75 also had an area on his left 5th toe that was from "rubbing on his shoe." RN-A stated the toe was red and R75 had a protective dressing on it.<br><br>During observation on 4/14/21, at 9:30 a.m. R75 had a hard calloused area on his left fifth toe. R75 complained of pain when palpated by the nurse. On R75's right foot, his toes appeared to be contracted and the first, second, fourth and fifth knuckles of his toes were reddened.<br><br>During interview on 4/14/21, at 12:25 p.m. RN-A stated she had a "thing" on her calendar that popped up every week to take a look at R75's toes but stated she was unsure the last time she had seen them. RN-A stated she thought she saw the toes two weeks ago but did not remember if she had documented the assessment. RN-A stated there was currently no assessment tool she was using to document regular skin assessments. The facility was currently not documenting weekly skin assessments during bathing and stated it was an area that was lacking. The nursing assistants (NA)'s were looking at the skin on bath days. RN-A stated she was not aware R75's toes were contracted prior to the assessment that morning. | F 684 | to be to the daily IDT meeting. Training for the Case Managers will be completed regarding skin condition, management at the floor level with collaboration on severe non-responding wounds with PT.<br>3.To assure that this deficient practice does not occur in the future the facility has completed training for all those staff members responsible to this regulatory tag. Training for the Case Managers regarding the MDS Assessment and Care Planning process to assure these two entries are consistent. Also the Case Managers responsibility to timely and consistent monitoring of skin condition/ needs. Training of the floor staff (LPNs/CNAs) who care for the residents to assure they understand changes and how to recognize them and what follow through is needed. Training completed by 05-12-2021.<br>4.To assure this practice enhancement is sustainable and hardwired the nursing leadership (Case Managers and Director of Nursing) shall complete audits as follows: a. Audits will be completed on those residents who have been identified in the IDT meeting as having skin concerns, by the Director of Nursing to include reviewing the progress notes  MDS and Care Plans as appropriate, as they occur: daily for the first 2 weeks; then twice a week for the next 4 weeks and randomly | |

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 684 | Continued From page 10<br><br>On 4/14/21, at 12:58 p.m. the director of nursing (DON) stated skin was assessed on the residents bath day. The NA's observed the skin and notified the charge nurse if they saw anything outside the normal. She was not sure where skin assessments were being documented and stated she was planning to implement an assessment. The DON was not aware R75 had problems with his feet but stated she knew he had complained of pain and it was discussed at an interdisciplinary team meeting and thought it was related to Gout. The DON stated she felt the NA's should have noticed the concerns with R75's feet.<br><br>A facility Wound Care Monitoring Guidelines dated 6/20, indicated a wound care RN was assigned to monitor wounds and wound care. The policy identified risk factors for skin breakdown and directed staff to observe, measure all facility wounds as well as apply dressings as ordered and to add weekly or monthly skin updated monitoring flowsheet and indicated RN to complete weekly observation, measurement and documentation on all wounds. | F 684 | thereafter.<br>b. Audits will be completed daily by the Case Managers regarding<br>timely floor reporting from the CNAs to the LPNS to the report process<br>to assure that the process is working.<br>Daily for the first 3 weeks; then<br>twice a week for the next 4 weeks and randomly thereafter.<br>c. These audit results will be reviewed at the quarterly QA&A meetings.<br>5.Completion date: 05-12-2021 | |
| F 686 SS=D | Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)<br><br>§483.25(b) Skin Integrity<br>§483.25(b)(1) Pressure ulcers.<br>Based on the comprehensive assessment of a resident, the facility must ensure that-<br>(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and<br>(ii) A resident with pressure ulcers receives | F 686 | | 5/12/21 |

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|

F 686

Continued From page 11

necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 1 residents (R14) who was at risk for pressure ulcers.

Findings include:

R14's annual Minimum Data Set (MDS) dated 2/24/21, indicated R14 had severe cognitive impairment and was totally dependent on staff for bed mobility and transfers. R14's diagnoses included non-Alzheimer's dementia and palliative care. R14's MDS indicated she was at risk for development of pressure ulcers with no current pressure ulcers.

Braden Scale for Predicting Pressure Sore Risk dated 2/24/21, identified R14 was at high risk for developing pressure ulcers; however, did not identify any interventions to prevent pressure ulcers.

R14's care plan dated 4/19/19, indicated R14 had a self care deficit and required to be repositioned at least every two hours while in bed and every hour when in her wheel chair. R14 had a skin integrity issue related to a history of a stage 2 pressure ulcer to coccyx (tailbone) dated 7/2/20, and required repositioning every two hours while in bed dated 4/13/21.

The nursing assistant care sheet dated 4/13/21, indicated R14 needed repositioning every hour

F 686

Lakewood Care Center does provide treatments and services to prevent/heal pressure ulcers. The facility does recognize that during its annual survey 1 resident; resident # 14 was not repositioned in accordance with the assessment determination for this resident (every 1 hour when in the chair and every 2 hours while in bed) this happened once when the resident was in the chair and once when resident was in the bed.
1.Regarding resident # 14; Although the Braden scale indicated the resident was at risk for skin breakdown and the Care Plan indicated interventions to turn and reposition every hour in chair and every 2 hours in bed and the CNA group sheets indicated the same; The facility does recognize twice during the survey the resident did not receive what the CP interventions required. In the spirit of cooperation the resident has been placed on a 2-day tissue tolerance assessment to assure the every 1 hour while up in the chair and every 2 hours while in bed plan of care still meets the resident□s needs.
2.Regarding all other residents who reside in the facility who might be

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 686 | Continued From page 12<br>while in wheel chair and every two hours while in bed.<br><br>During continuous observation on 4/13/21, from 1:25 p.m. to 3:30 p.m. (2 hours and 5 minutes). R14 was seated in her wheel chair, with the back reclined. R14 was not repositioned during that time.<br><br>During interview on 4/13/21, at 3:45 p.m. nursing assistant (NA)-A stated R14 was to be repositioned every 2 hours while in wheel chair and in bed; however, identified the nursing assistant care sheet does say to reposition every hour while in her wheel chair. NA-A stated R14 was not repositioned in a timely manner in her wheel chair and should have been.<br><br>During interview on 4/13/21, at 3:48 p.m. licensed practical nurse (LPN)-A stated the nursing assistant care sheet was wrong and it was supposed to say R14 was to be repositioned every 2 hours and was now in the process of being changed. LPN-A did not comment on R14's care plan which indicated R14 was to repositioned every hour while in wheel chair and every two hours while in bed.<br><br>R14's medical record lacked an assessment on positioning frequency.<br><br>During interview on 4/13/21, at 3:53 p.m. registered nurse (RN)-A ,who was the unit coordinator, stated she would expect the NA's and the LPN's to follow the care plan and nursing assistant care sheets. R14 should be repositioned every hour in the wheel chair and every two hours in bed due to her history of having a pressure ulcer. RN-A stated there were | F 686 | affected by this deficient practice; their medical records have been reviewed and revised as necessary to assure accuracy of their care plans.<br>3.To assure that this deficient practice does not occur in the future the facility has completed training for those staff members responsible to this regulatory tag. The process for communicating to the floor staff has been enhanced to promote accurate and timely transfer of information.<br>Training for the Case Managers regarding care planning and assessments such as but not limited to the tissue tolerance process and Braden scale were reviewed to include timely and accurate dissemination of information between all staff. Floor staff (PLNs and CNAs) were retrained to their responsibility to know their resident□s needs and report changes that take place as soon as they appear.<br>4.To assure this practice enhancement is sustainable and hardwired the nursing leadership (Case Managers and Director of Nursing) shall complete audits as follows:<br>a. The DON will complete Audits of the medical record to include the MDS/CAAs, progress notes assessment and the plan of care on new admissions, hospital readmissions and changes of condition reported in the IDT meeting as they occur for the next 2 months and the randomly thereafter. | |

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 686 | Continued From page 13<br>no pending or recent changes to nursing assistant care sheets.<br><br>During observation on 4/14/21, at 6:54 a.m. NA-E and NA-C went in with R14 and repositioned her from her right side to her left side.<br><br>During continuous observation on 4/14/21, from 7:00 a.m. through 10:20 a.m. (3 hours and 20 minutes) no one was observed to enter the room and reposition the resident.<br><br>During interview on 4/14/21, at 10:20 a.m. NA-E stated R14 would be repositioned every 2 hours while in bed and she stated she had not repositioned R14 since 7:00 a.m. and R14 was not repositioned in a timely manner.<br><br>During observation on 4/14/21, at 10:38 a.m. RN-A performed a dressing change on R14's sacral area and no redness or open areas were identified. RN-A stated the dressing was used to help protect the skin where the previous pressure ulcer had been and would expected R14 to be repositioned every two hours while in bed.<br><br>The facility's Repositioning Policy dated 11/20, indicated it was the intent to provide adequate positioning for those who were not able to position themselves to avoid discomfort, impaired tissue integrity and mobility decline. | F 686 | b. The Case Managers will complete audits regarding staff knowledge of changes as they happen on any resident, daily for the first 3 days after a change to assure the staff are looking at their sheets and getting the information they need. These audits will continue on changes for the next 2 months.<br>c. These audit results will be reviewed at the quarterly QA&A meetings.<br>5.Completion date: 05-12-2021 | |
| F 695 SS=D | Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)<br><br>§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy | F 695 | | 5/6/21 |

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 695 | Continued From page 14<br>care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to ensure respiratory care equipment was cleaned and maintained according to the facility's policy to prevent potential contamination for 1 of 1 resident (R23) who had a history of respiratory infections, was currently receiving treatment for sinusitis and used oxygen on an ongoing basis.<br><br>Finding include:<br><br>R23's admission Minimum Data Set (MDS) dated 1/24/21, identified R23 had intact cognition. R23 required continuous oxygen therapy and had a diagnosis of chronic obstructive pulmonary disease (COPD).<br><br>R23's physician orders dated 4/13/21, included orders for oxygen at 4 to 5 liters (L) per nasal cannula continuous every shift for COPD. Further R23's oxygen concentrator and mesh filters were to be cleaned and oxygen tubing changed weekly on Tuesdays.<br><br>On 4/13/21, at at 10:01 a.m. R23 was interviewed and explained she was currently receiving antibiotic treatment for a respiratory infection. R23 used oxygen at all times for COPD and had been in the hospital in January with pneumonia. The facility was suppose to change her nasal cannula on her oxygen tubing weekly but they did not always change it weekly. R23 date identified | F 695 | Lakewood Care Center does have a process in place to assure that respiratory equipment is cleaned and maintained to prevent potential contamination/infection.<br>The facility does recognize that during its annual survey 1 resident;<br>resident # 23 did not have their oxygen tubing changed timely<br>(process requires changing of said tubing weekly and the nurse must<br>tag the tubing with date and initials of the nurse). It was not possible<br>to determine if the tubing for Resident # 23 had been changed weekly.<br>The medical record indicated that the tubing had been changed at the<br>proper weekly interval but the tag date indicated that 2 weeks had<br>elapsed since the last tubing change.<br>1.Regarding resident # 23; the resident□s medical record was reviewed<br>to assure documentation was current and the tubing was changed as<br>the time of identification during the survey (4/13/21). Audits since that<br>time (weekly) have shown that they have been timely and tagged in<br>accordance with our policy.<br>2.Regarding all other residents who reside in the facility who might be<br>affected by this deficient practice their | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **245580** | A. BUILDING ______<br>B. WING ______ | C<br>**04/15/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKEWOOD CARE CENTER** | **600 MAIN AVENUE SOUTH**<br>**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 695 | Continued From page 15<br>on the oxygen tubing was dated 3/31/21, two weeks prior.<br><br>When interviewed on 4/13/21, at 1:09 p.m. licensed practical nurse (LPN)-C stated oxygen tubing was changed weekly by the night shift. LPN-C indicated R23's tubing had not been changed and she would change it. Oxygen tubing was to be changed weekly to prevent bacterial growth and she was not sure why it had not been done.<br><br>When interviewed on 4/13/21, at 3:49 p.m. registered nurse (RN)-B stated oxygen tubing was changed weekly to help prevent build up of things in the nasal cannula. She did not know why R23's tubing was not changed<br><br>During interview on 4/14/21, at 1:38 p.m. the director of nursing (DON) stated oxygen tubing was to be changed weekly and R23's nasal cannula should have been changed every week.<br><br>The facilities Oxygen Administration policy revised 12/20, indicated all oxygen delivery systems were checked at least once per day. Weekly cleaning of the equipment, as well as changing of all ancillary equipment will take place. | F 695 | medical records were reviewed to assure documentation was accurate and their oxygen changing times were checked to assure timely changes were completed accurately and corrected, as necessary. At time resident #23 is the only resident on O2.<br>A secondary change has been made to this tubing change process taking this responsibility off the night shift and placing it on the day shift.<br>This change is mainly to recognize that waking a resident to change oxygen tubing on the night shift does not promote quality sleep time.<br>3.To assure that this deficient practice does not occur in the future the facility has completed training with those staff members responsible to this regulatory tag to assure there is solid understanding of the process.<br>4.To assure this practice enhancement is sustainable and hardwired the nursing leadership (Case Managers) shall complete audits as follows:<br>a.The Case Managers will complete audits on all their resident who use oxygen □ they will audit according to each resident□s oxygen change time for the next 4 weeks □ then randomly for the next 2 months.<br>These audit results will be reviewed at the quarterly QA&A meetings.<br>5.Completion date: 05-06-2021 | |
| F 842<br>SS=D | Resident Records - Identifiable Information<br>CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) | F 842 | | 5/12/21 |

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 16 | F 842 | | |

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 17<br><br>§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.<br><br>§483.70(i)(4) Medical records must be retained for-<br>(i) The period of time required by State law; or<br>(ii) Five years from the date of discharge when there is no requirement in State law; or<br>(iii) For a minor, 3 years after a resident reaches legal age under State law.<br><br>§483.70(i)(5) The medical record must contain-<br>(i) Sufficient information to identify the resident;<br>(ii) A record of the resident's assessments;<br>(iii) The comprehensive plan of care and services provided;<br>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;<br>(v) Physician's, nurse's, and other licensed professional's progress notes; and<br>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the medical chart to ensure resident wishes would be implemented correctly in an emergent situation in event breathing and pulse ceased for 1 of 12 residents (R9) reviewed for advanced directives.<br><br>Findings include:<br><br>R9's quarterly Minimal Data Set (MDS) dated | F 842 | Lakewood Care Center does assure that the residents residing in the facility have current and accurate DNR statuses in their medical record.<br>The facility does recognize that during its annual survey 1 resident;<br>resident # 9, was missing the proper DNR document in the paper portion of the medical record. And that the Care conferences did not identify the resident□s DNR wishes.<br>1.Regarding resident # 9; The resident□s | |

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 18<br>3/3/21, identified R9 had intact cognition. Diagnoses included cerebral infarction (stroke, a brain lesion in which a cluster of brain cells die when they do not get enough blood), occlusion and stenosis of the anterior cerebral artery, transient cerebral ischemic attack and hypertension (high blood pressure).<br><br>R9's care plan dated 10/19/20, identified an advanced directive focus with the outcome: R9 would have up to date advanced directives on file. Interventions were for staff to ensure advanced directives and code status were reviewed at care conferences quarterly and as needed (PRN). The care plan did not identify a code status preference.<br><br>R9's medical record did not include orders that would identify if R9 was to have staff attempt resuscitation(CPR) or do not attempt resuscitation (DNR) and his electronic medical record lacked a delegated code status to alert staff of his wishes.<br><br>R9's Order Summary Report did not identify a code status.<br><br>R9's medical record contained a Five Wishes plan to indicate R9's wishes for the person he wanted to make care decisions for him, the kind of medical treatment he would want or not want, how comfortable he wanted to be, how he wanted to be treated and what he wanted his loved ones to know. This form indicated R9 wanted to have life-support treatment if he was close to death, in a coma and not expected to recover, or had permanent and severe brain damage and not expected to recover if his doctor believed it would help but would want his doctor to stop giving him | F 842 | medical record and DNR status was reviewed for accuracy and the current DNR status is now in the front of the chart as it should be.<br>2.Regarding all other residents who reside in the facility who might be affected by this deficient practice; the resident□s medical records and DNR statuses have been reviewed for accuracy and to assure that all those resident□s DNR statuses are in the front of the chart. The facility has a process by which the care conference information documented during the care conference. The facility reviewed and revised the process; making changes to better assure this deficient practice does not happen again to include moving the DNR status responsibility to the Case Manager managing the residents□ plan of care .The DNR code status will be tied to the clinical assessment process on admission, hospital return and any significant change. An enhancement to the care conference process will include completing user friendly information from the care conference in a summary that can be given to the resident/or responsible party for review.<br>3.To assure that this deficient practice does not occur in the future the facility has completed training to the staff members responsible to this regulatory tag. The DNR status has been shifted to the Case Manages on admission and during any change.<br>4.To assure this practice enhancement is | |

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 19<br>life-support treatment if it was not helping his health condition or symptoms. The form was signed by R9 and notarized on January 5, 2018.<br><br>During interview on 4/13/21, at 2:46 p.m. licensed practical nurse (LPN)-C stated a resident's code status was identified on the electronic medical record (EMR) underneath the residents name and picture. If she was unable to find the code status there she would look at the resident's hard copy chart. LPN-C was unable to find R9's code status in his EMR or his hard copy chart, however identified his Five Wishes form would be used as a reference for his advanced directives. LPN-C reviewed R9's Five Wishes form, and after several minutes stated R9 would be a full code or CPR status.<br><br>During interview on 4/13/21, at 2:53 p.m. registered nurse (RN)-B stated resident's advanced directive forms were located in the front of their hard copy charts and in the EMR under their picture. R9 should have had a code status form in his chart as well as the Five Wishes document. RN-B stated it was difficult to quickly determine what R9's code status would be from reading his Five Wishes form but it looked like he wanted to be a full code. If a resident did not have a code status delegated, the facility policy was to perform CPR. RN-B was unable to locate a code status order in his physician orders and stated all residents were suppose to have orders for code status.<br><br>When interviewed on 4/13/21, at 3:39 p.m. licensed social worker (LSW)-A stated he went over the code status with residents and their representatives at admission as well as the Five Wishes document, as both forms were in the | F 842 | sustainable and hardwired the nursing leadership (Case Managers and Director of Nursing) shall complete audits as follows:<br>a. The Director of Nursing shall audit all new admissions/status changes for the next 3 months to assure that the medical record is current and accurate to the resident□s DNR wishes.<br>b. The Case Manager will audit each other□s care conference summary sheets for follow through □ all care conferences for the next 4 weeks and then randomly ongoing.<br>c. These audit results will be reviewed at the quarterly QA&A meetings.<br>5.Completion date: 05-12-2021 | |

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 20 | F 842 | | |

admission packet. His usual procedure was to go through the forms with them on admission and get it into their chart. If it was a newly filled out form, he would send it to the residents doctor for signature. When he assisted a resident with a new advanced directive his practice was to have the patient or representative sign the document as well as have a nurse sign as a witness. LSW-A remembered having the discussion with R9 and his spouse on admission and he may have sent it to R9's doctor for signature and had never gotten the form back. He reviewed advanced directives at resident care conferences and made a notation in the resident chart. LSW-A was unable to find any documentation advanced directives were reviewed during care conferences for R9 and was unable to find an advanced directive form in R9's medical record.

On 4/13/21, at 3:41 p.m. LSW-A provided a copy of R9's advanced directive form that indicated R9 was a DNR/DNI code status. The form was signed and dated 7/9/20. LSW-A stated he had found the form in R9's admission packet papers in his office.

During interview on 4/14/21, at 1:38 p.m. the director of nursing (DON) stated the admitting nurse or the social worker were responsible to speak with an admitting resident and their family about code status. There was a check list in the admission packet they referred to and code status was indicated on the check list so they could check it off when they do it. There should be a CPR code sheet in all resident charts. R9's was just missed by accident.

The facility Advance Directives policy revised 7/17, indicated the facility would follow and

| 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 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 842 | Continued From page 21 | F 842 | | |

implement any all advance directives recognized under federal and state law. The policy identified procedures to inform the admitting nurse and medical records of advanced directive(s) status and provide a copy of any advance directive(s) to be placed on chart. Advance directive information was to be documented in the social history, social services assessment and social services progress notes and documented on the resident's initial care plan. Review of advance directive status with the resident or legal entity was to be done each time the care plan was reviewed. The admitting nurse would identify advanced directive status on the nursing assessment form and contact the physician for the appropriate doctor orders pertaining to any advance directives, and document in the nursing notes.

The facility Health Care Directives policy revised 6/20, indicated if there was no written order limiting medical treatment, there would be every attempt to provide life-sustaining measures. if the physician writes an order for DNR/DNI the patient will not receive life-sustaining measures. The DNR/DNI status would be reviewed on a regular basis, quarterly care conferences, post hospital care conferences, or on the request from the patient, family or legal representative.

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

Electronically delivered
April 29, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: B3WW11

Dear Administrator:

The above facility was surveyed on April 12, 2021 through April 15, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Jen Bahr, RN, Unit Supervisor
Bemidji District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, MN 56601-2933
Email: Jennifer.bahr@state.mn.us
Office: (218) 308-2104 Mobile: (218) 368-3683

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

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Initial Comments | 2 000 | | |

*****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 4/12/21 through 4/15/21, a licensing and complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Continued From page 1 | 2 000 | | |

have reviewed these orders, and identify the date when they will be completed.

The following complaints were found to be SUBSTANTIATED:
H5580008C (MN64597)
H5580010C (MN57495)
H5580011C (MN53740)

However, no deficiencies were cited for the complaints due to actions taken by the facility prior to investigation.

The complaint H5580009C (MN59433) was found to be UNSUBSTANTIATED

The Minnesota Department of Health, Licensure and Certification surveyors visited Lakewood Care Center and the following correction orders were issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

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. State licensing orders are delineated on 2567, under the Minnesota Department of Health licensing order statute(s) 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 on the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting your plan of correction to the Minnesota Department of Health.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ___ B. WING ___ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 000 | Continued From page 2<br><br>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.<br>The assigned tag number appears in the far left column entitled "ID Prefix Tag". The state statute/rule found 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 surveyors findings are the "Suggested Method of Correction" and the "Time Period for Correction".<br><br>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. | 2 000 | | |
| 2 625 | MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General<br><br>Subpart 1. In general. Each resident's clinical record, including nursing notes, must include:<br>A. the condition of the resident at the time of admission;<br>B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I;<br>C. the resident's height and weight, | 2 625 | | 5/12/21 |

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ____ B. WING ____ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 625 | Continued From page 3 | 2 625 | | |

according to part 4658.0520, subpart 2, item J;
D. the resident's general condition, actions, and attitudes;
E. observations, assessments, and interventions provided by all disciplines responsible
for care of the resident, with the exception of confidential communications with
religious personnel;
F. significant observations on, for example, behavior, orientation, adjustment to the
nursing home, judgment, or moods;
G. date, time, quantity of dosage, and method of administration of all medications, and
the signature of the nurse or authorized persons who administered the medication;
H. a report of a tuberculin test within the three months prior to admission, as described
in part 4658.0810;
I. reports of laboratory examinations;
J. dates and times of all treatments and dressings;
K. dates and times of visits by all licensed health care practitioners;
L. visits to clinics or hospitals;
M. any orders or instructions relative to the comprehensive plan of care;
N. any change in the resident's sleeping habits or appetite;
O. pertinent factors regarding changes in the resident's general conditions; and
P. results of the initial comprehensive resident assessment and all subsequent
comprehensive assessments as described in part 4658.0400.

This MN Requirement is not met as evidenced by:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 625 | Continued From page 4<br><br>Based on interview and document review the facility failed to ensure advanced directives for emergency care and treatment were accurately reflected in all areas of the medical chart to ensure resident wishes would be implemented correctly in an emergent situation in event breathing and pulse ceased for 1 of 12 residents (R9) reviewed for advanced directives.<br><br>Findings include:<br><br>R9's quarterly Minimal Data Set (MDS) dated 3/3/21, identified R9 had intact cognition. Diagnoses included cerebral infarction (stroke, a brain lesion in which a cluster of brain cells die when they do not get enough blood), occlusion and stenosis of the anterior cerebral artery, transient cerebral ischemic attack and hypertension (high blood pressure).<br><br>R9's care plan dated 10/19/20, identified an advanced directive focus with the outcome: R9 would have up to date advanced directives on file. Interventions were for staff to ensure advanced directives and code status were reviewed at care conferences quarterly and as needed (PRN). The care plan did not identify a code status preference.<br><br>R9's medical record did not include orders that would identify if R9 was to have staff attempt resuscitation(CPR) or do not attempt resuscitation (DNR) and his electronic medical record lacked a delegated code status to alert staff of his wishes.<br><br>R9's Order Summary Report did not identify a code status.<br><br>R9's medical record contained a Five Wishes | 2 625 | Completed | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ____ B. WING ____ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 625 | Continued From page 5<br>plan to indicate R9's wishes for the person he wanted to make care decisions for him, the kind of medical treatment he would want or not want, how comfortable he wanted to be, how he wanted to be treated and what he wanted his loved ones to know. This form indicated R9 wanted to have life-support treatment if he was close to death, in a coma and not expected to recover, or had permanent and severe brain damage and not expected to recover if his doctor believed it would help but would want his doctor to stop giving him life-support treatment if it was not helping his health condition or symptoms. The form was signed by R9 and notarized on January 5, 2018.<br><br>During interview on 4/13/21, at 2:46 p.m. licensed practical nurse (LPN)-C stated a resident's code status was identified on the electronic medical record (EMR) underneath the residents name and picture. If she was unable to find the code status there she would look at the resident's hard copy chart. LPN-C was unable to find R9's code status in his EMR or his hard copy chart, however identified his Five Wishes form would be used as a reference for his advanced directives. LPN-C reviewed R9's Five Wishes form, and after several minutes stated R9 would be a full code or CPR status.<br><br>During interview on 4/13/21, at 2:53 p.m. registered nurse (RN)-B stated resident's advanced directive forms were located in the front of their hard copy charts and in the EMR under their picture. R9 should have had a code status form in his chart as well as the Five Wishes document. RN-B stated it was difficult to quickly determine what R9's code status would be from reading his Five Wishes form but it looked like he wanted to be a full code. If a resident did not have a code status delegated, the facility policy | 2 625 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 625 | Continued From page 6<br>was to perform CPR. RN-B was unable to locate a code status order in his physician orders and stated all residents were suppose to have orders for code status.<br><br>When interviewed on 4/13/21, at 3:39 p.m. licensed social worker (LSW)-A stated he went over the code status with residents and their representatives at admission as well as the Five Wishes document, as both forms were in the admission packet. His usual procedure was to go through the forms with them on admission and get it into their chart. If it was a newly filled out form, he would send it to the residents doctor for signature. When he assisted a resident with a new advanced directive his practice was to have the patient or representative sign the document as well as have a nurse sign as a witness. LSW-A remembered having the discussion with R9 and his spouse on admission and he may have sent it to R9's doctor for signature and had never gotten the form back. He reviewed advanced directives at resident care conferences and made a notation in the resident chart. LSW-A was unable to find any documentation advanced directives were reviewed during care conferences for R9 and was unable to find an advanced directive form in R9's medical record.<br><br>On 4/13/21, at 3:41 p.m. LSW-A provided a copy of R9's advanced directive form that indicated R9 was a DNR/DNI code status. The form was signed and dated 7/9/20. LSW-A stated he had found the form in R9's admission packet papers in his office.<br><br>During interview on 4/14/21, at 1:38 p.m. the director of nursing (DON) stated the admitting nurse or the social worker were responsible to speak with an admitting resident and their family | 2 625 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 625 | Continued From page 7 | 2 625 | | |

about code status. There was a check list in the admission packet they referred to and code status was indicated on the check list so they could check it off when they do it. There should be a CPR code sheet in all resident charts. R9's was just missed by accident.

The facility Advance Directives policy revised 7/17, indicated the facility would follow and implement any all advance directives recognized under federal and state law. The policy identified procedures to inform the admitting nurse and medical records of advanced directive(s) status and provide a copy of any advance directive(s) to be placed on chart. Advance directive information was to be documented in the social history, social services assessment and social services progress notes and documented on the resident's initial care plan. Review of advance directive status with the resident or legal entity was to be done each time the care plan was reviewed. The admitting nurse would identify advanced directive status on the nursing assessment form and contact the physician for the appropriate doctor orders pertaining to any advance directives, and document in the nursing notes.

The facility Health Care Directives policy revised 6/20, indicated if there was no written order limiting medical treatment, there would be every attempt to provide life-sustaining measures. if the physician writes an order for DNR/DNI the patient will not receive life-sustaining measures. The DNR/DNI status would be reviewed on a regular basis, quarterly care conferences, post hospital care conferences, or on the request from the patient, family or legal representative.

SUGGESTED METHODS OF CORRECTION:

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 625 | Continued From page 8<br>The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure complete, timely, and accurate documentation was kept current for all residents. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the monitoring results to the quality assurance committee for further recommendations.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 625 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide regular monitoring of ongoing skin conditions to ensure progress in healing for 1 of 1 residents (R75) reviewed for non-pressure related skin concerns. | 2 830 | Completed | 5/12/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 9 | 2 830 | | |

Findings include:

R75's quarterly Minimum Data Set (MDS) dated 3/3/21, indicated R75 had moderate cognitive impairment and was independent with activities of daily living; however, required assistance with bathing. The MDS identified R75 was not at risk for pressure ulcers, had no venous or arterial ulcers, no open lesions including cancer lesions and did not receive any treatments to skin including his feet.

R75's care plan dated 3/11/21, identified a skin tear related to fragile skin and impaired skin integrity with a growth on his posterior scalp related to cancer. The care plan further identified a history of a left heel fissure as well as dry, cracked heels and directed staff to apply ointment to both heels as needed and treatment and dressing change of "location" per provider direction.

R75's Treatment Administration Record (TAR) dated April 2021, indicated the following orders:

- Dressing to left pinky toe and left foot sole, planter wart location weekly and as needed with a start date of 2/18/21.

- Apply lotion topically to both heels daily for dry, cracked heels with a start date of 3/18/21.

R75's physician visit note dated 3/16/21, indicated R75 was seen related to skin concerns on R75's right thumb, left foot and older skin tears on the left arm. R75 reported pain on the left 5th toe and some pain with pressure to the ball of his foot. The physical exam indicated: Bilateral feet with very dry and thick peeling skin on the heels.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 10<br>Bilateral heels are boggy, 1.5 centimeter (cm) plantar wart on ball of left foot, 1 cm corn on left fifth toe.<br><br>R75's progress note dated 3/16/21, indicated R75 was seen in clinic for plantar wart on left foot, right thumb growth and skin tear follow up.<br><br>R75's medical record lacked evidence R75's skin and feet were assessed.<br><br>On 4/14/21, at 8:22 a.m. registered nurse (RN)-A stated R75 had fissures on his heels and a plantar wart on the sole of his foot. RN-A stated R75 also had an area on his left 5th toe that was from "rubbing on his shoe." RN-A stated the toe was red and R75 had a protective dressing on it.<br><br>During observation on 4/14/21, at 9:30 a.m. R75 had a hard calloused area on his left fifth toe. R75 complained of pain when palpated by the nurse. On R75's right foot, his toes appeared to be contracted and the first, second, fourth and fifth knuckles of his toes were reddened.<br><br>During interview on 4/14/21, at 12:25 p.m. RN-A stated she had a "thing" on her calendar that popped up every week to take a look at R75's toes but stated she was unsure the last time she had seen them. RN-A stated she thought she saw the toes two weeks ago but did not remember if she had documented the assessment. RN-A stated there was currently no assessment tool she was using to document regular skin assessments. The facility was currently not documenting weekly skin assessments during bathing and stated it was an area that was lacking. The nursing assistants (NA)'s were looking at the skin on bath days. RN-A stated she was not aware R75's toes were contracted prior | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 830 | Continued From page 11<br>to the assessment that morning.<br><br>On 4/14/21, at 12:58 p.m. the director of nursing (DON) stated skin was assessed on the residents bath day. The NA's observed the skin and notified the charge nurse if they saw anything outside the normal. She was not sure where skin assessments were being documented and stated she was planning to implement an assessment. The DON was not aware R75 had problems with his feet but stated she knew he had complained of pain and it was discussed at an interdisciplinary team meeting and thought it was related to Gout. The DON stated she felt the NA's should have noticed the concerns with R75's feet.<br><br>A facility Wound Care Monitoring Guidelines dated 6/20, indicated a wound care RN was assigned to monitor wounds and wound care. The policy identified risk factors for skin breakdown and directed staff to observe, measure all facility wounds as well as apply dressings as ordered and to add weekly or monthly skin updated monitoring flowsheet and indicated RN to complete weekly observation, measurement and documentation on all wounds.<br><br>A SUGGESTED METHOD FOR CORRECTION: The DON or designee could review and revise the policies and procedures related to monitoring of ongoing skin conditions. She or designee could provide education to all involved staff. The facility could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee.<br><br>TIME PERIOD FOR CORRECTION: Twenty one (21) days. | 2 830 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers<br><br>Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:<br><br>A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and<br><br>B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide timely repositioning for 1 of 1 residents (R14) who was at risk for pressure ulcers.<br><br>Findings include:<br><br>R14's annual Minimum Data Set (MDS) dated 2/24/21, indicated R14 had severe cognitive impairment and was totally dependent on staff for bed mobility and transfers. R14's diagnoses included non-Alzheimer's dementia and palliative care. R14's MDS indicated she was at risk for development of pressure ulcers with no current pressure ulcers.<br><br>Braden Scale for Predicting Pressure Sore Risk | 2 900 | Completed | 5/12/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | Continued From page 13<br>dated 2/24/21, identified R14 was at high risk for developing pressure ulcers; however, did not identify any interventions to prevent pressure ulcers.<br><br>R14's care plan dated 4/19/19, indicated R14 had a self care deficit and required to be repositioned at least every two hours while in bed and every hour when in her wheel chair. R14 had a skin integrity issue related to a history of a stage 2 pressure ulcer to coccyx (tailbone) dated 7/2/20, and required repositioning every two hours while in bed dated 4/13/21.<br><br>The nursing assistant care sheet dated 4/13/21, indicated R14 needed repositioning every hour while in wheel chair and every two hours while in bed.<br><br>During continuous observation on 4/13/21, from 1:25 p.m. to 3:30 p.m. (2 hours and 5 minutes). R14 was seated in her wheel chair, with the back reclined. R14 was not repositioned during that time.<br><br>During interview on 4/13/21, at 3:45 p.m. nursing assistant (NA)-A stated R14 was to be repositioned every 2 hours while in wheel chair and in bed; however, identified the nursing assistant care sheet does say to reposition every hour while in her wheel chair. NA-A stated R14 was not repositioned in a timely manner in her wheel chair and should have been.<br><br>During interview on 4/13/21, at 3:48 p.m. licensed practical nurse (LPN)-A stated the nursing assistant care sheet was wrong and it was supposed to say R14 was to be repositioned every 2 hours and was now in the process of being changed. LPN-A did not comment on R14's | 2 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | Continued From page 14<br>care plan which indicated R14 was to repositioned every hour while in wheel chair and every two hours while in bed.<br><br>R14's medical record lacked an assessment on positioning frequency.<br><br>During interview on 4/13/21, at 3:53 p.m. registered nurse (RN)-A ,who was the unit coordinator, stated she would expect the NA's and the LPN's to follow the care plan and nursing assistant care sheets. R14 should be repositioned every hour in the wheel chair and every two hours in bed due to her history of having a pressure ulcer. RN-A stated there were no pending or recent changes to nursing assistant care sheets.<br><br>During observation on 4/14/21, at 6:54 a.m. NA-E and NA-C went in with R14 and repositioned her from her right side to her left side.<br><br>During continuous observation on 4/14/21, from 7:00 a.m. through 10:20 a.m. (3 hours and 20 minutes) no one was observed to enter the room and reposition the resident.<br><br>During interview on 4/14/21, at 10:20 a.m. NA-E stated R14 would be repositioned every 2 hours while in bed and she stated she had not repositioned R14 since 7:00 a.m. and R14 was not repositioned in a timely manner.<br><br>During observation on 4/14/21, at 10:38 a.m. RN-A performed a dressing change on R14's sacral area and no redness or open areas were identified. RN-A stated the dressing was used to help protect the skin where the previous pressure ulcer had been and would expected R14 to be repositioned every two hours while in bed. | 2 900 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 900 | Continued From page 15<br><br>The facility's Repositioning Policy dated 11/20, indicated it was the intent to provide adequate positioning for those who were not able to position themselves to avoid discomfort, impaired tissue integrity and mobility decline.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could in-service all staff responsible for giving cares/services on following the care plan exactly as directed to promote healing and prevent pressure ulcers from developing. The DON or designee could then conduct audits to ensure care and serves were being followed.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 900 | | |
| 2 915 | MN Rule 4658.0525 Subp. 6 A Rehab - ADLs<br><br>Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that:<br>A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to:<br>(1) bathe, dress, and groom;<br>(2) transfer and ambulate;<br>(3) use the toilet;<br>(4) eat; and<br>(5) use speech, language, or other functional communication systems; and | 2 915 | | 5/12/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 915 | Continued From page 16<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to ensure a resident was reassessed/referrals were completed to ensure appropriate interventions were initiated for a decline in activities of daily living for 1 of 1 resident (R4) reviewed for a decline in ADL's.<br><br>Findings include:<br><br>R4's quarterly Minimum Data set (MDS) dated 12/31/20, indicated R4 required extensive assistance from one staff for bed mobility, transfers, toileting and ambulation. R4's significant change MDS dated 3/24/21, identified R4 had moderate cognitive impairment and required total assistance from two staff for bed mobility, transfers and toileting and total assistance from one staff to eat and complete personal hygiene. The MDS indicated R4 did not ambulate.<br><br>R4's ADL care area assessment (CAA) dated 3/29/21, triggered due to total dependence on staff for bed mobility, transfer, locomotion, eating, toileting and personal hygiene needs. The CAA had multiple system pre-populated checks for possible underlying problems indicated delirium, changing cognitive status, communications and mood decline. Risk factor due to decline indicated incontinence and depression. Input from resident and/or representative was not obtained. Care plan consideration included maintain current level of function and minimize risk. Referral to another discipline indicated "no". The problem/need indicated "residents overall health decline" due to | 2 915 | Completed | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 915 | Continued From page 17 | 2 915 | | |

stroke, and required total care, without further analysis or interventions identified.

R4's care plan dated 3/31/21, identified R4 had a self care deficit related to a history of a cerebral vascular accident (stroke). The care plan directed staff to provide extensive assistance with transfers using a mechanical lift. The care plan indicated R4 was independent with bed mobility and did not participate in hygiene related to toileting.

R4's undated nursing assistant (NA) care sheet Lakewood Care Center Group 1, indicated "resident unable to walk - if begins to attempt will need PT (physical therapy) consult.

During observation on 4/12/21, at 2:39 p.m. R4 was lying in bed with his eyes closed. R4's bed was lowered all the way to the floor and had a full size mattresses on each side. At 5:04 p.m. R4 was seated in a wheel chair next to the medication cart and was asking what was for dinner. At 7:04 p.m. R4 was back in bed.

On 4/13/21, at 10:43 a.m. R4 was in bed. At 11:40 a.m. R4 remained in bed while other residents on the unit ate lunch. At 1:04 p.m. R4 remained in bed.

R4's progress note(s) identified the following:

- 2/12/21, R4 returned from the hospital, condition indicated returned to baseline.

- 2/14/21, R4 requested to use the bathroom twice. Staff assisted both times using walker. R4 stood and transferred well then assisted with walker and gait belt to bed.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ____ B. WING ____ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 915 | Continued From page 18 | 2 915 | | |

- 2/16/21, R4 has had a progressive decline over the past couple of months. Some days not cooperative or comprehending, other days compliant with contact guard assist and pivot transfers successful.

- 2/27/21, R4 continued to have no additional changes since previous review. Baseline continued to fluctuate with left sided weakness noted. One or two days per week R4 was able to complete pivot transfer to chair next to bed and other times required mechanical lift.

- 3/16/21, R4 required the use of a mechanical lift to get out of bed.

- 3/20/21, R4 continued to progress to the use of a mechanical lift with all transfers over the past couple of weeks.

- 3/24/21, Significant change assessment. R4 had a decline in his ADL status in the last couple of weeks and was requiring more help with ADL's.

- 4/6/21, Care conference with no specified nursing concerns.

- 4/13/21, R4's transfer status had progressed to full mechanical lift for transfers. Care plan was updated to total assistance from two staff for transfers. Previously stated contact guard assistance from one to two staff using a gait belt and walker. If R4 were to attempt to be mobile with attempts to walk a PT evaluation would be appropriate.

On 4/13/21, at 3:33 p.m.. licensed practical nurse (LPN)-A stated R4 had declined in ability, R4 did not want to get out of bed, and slept most of the time. LPN-A stated when R4 was up he was

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 915 | Continued From page 19<br>unable to feed himself. R4 had not been receiving therapy services but did not know why.<br><br>At 3:36 p.m. registered nurse (RN)-A stated R4 had been hospitalized in February 2021, the hospital wanted to send him to either Fargo or Grand Forks but family had declined. RN-A stated when R4 returned from the hospital he was at his baseline for ADL's but had since had a significant change in his abilities. RN-A stated R4 had not been referred to therapy and was not sure at what point therapy should have been recommended. Further, RN-A had been completing the MDS assessments but stated there were some "pieces missing" related to the CAA's. She was still learning and was not really sure what the CAA entailed or what it was used for.<br><br>At 3:48 p.m. the director of nursing (DON) stated the significant change in status should have had been discussed in the interdisciplinary team (IDT) meeting. The DON stated R4's need for a therapy evaluation should have been discussed and documented by RN-A, and should have been referred to therapy for an evaluation.<br><br>On 4/14/21, at 1:06 p.m. physical therapist (PT)-A stated the IDT had a meeting weekly in which they discussed anyone who had returned from the hospital and discussed residents status. PT-A stated residents who needed a therapy evaluation would have been addressed at that time. PT-A stated following R4's hospitalization he had been able to complete a stand pivot transfer. A therapy referral was not generated because R4 was not walking and stated, "he has to be moving". PT- A stated in R4's case a therapy evaluation had not been done following the significant change because he was not ambulatory. PT-A stated "if he was still walking....... but he is at the highest | 2 915 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 915 | Continued From page 20<br><br>level of care." Further, PT-A did not screen R4 for potential treatment related to the decline in other ADL abilities.<br><br>A facility Rehab Services policy dated 5/3/10, indicated physical medicine programs involved intense, comprehensive and educational and physical therapeutic procedures and exercised and should be justified in terms of their contribution to returning the injured patient to their previous functional status. The policy indicated an initial evaluation to be completed; however, did not identify when therapy would be appropriate during the course of a residents long term stay at the facility.<br><br>The Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual Version 1.17.1 dated 11/19, identified "The CAA process provides guidance on how to focus on key issues identified during a comprehensive MDS assessment and directs facility staff and health professionals to evaluate triggered care areas. After obtaining input from the resident, the resident's family, significant other, guardian, or legally authorized representative, the IDT decides whether or not to develop a care plan for triggered care areas. the CAA process provides for further assessment of the triggered areas by guiding staff to look for causal or confounding factors, some of which may be reversible. It is important that the CAA documentation include the causal or unique risk factors for decline or lack of improvement. The plan of care then addresses these factors, with the goal of promoting the resident ' s highest practicable level of functioning: (1) improvement where possible, or (2) maintenance and prevention of avoidable declines. Documentation should support your decision making regarding whether to proceed | 2 915 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00332 | A. BUILDING: ______ B. WING ______ | C 04/15/2021 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
|---|---|---|---|---|
| 2 915 | Continued From page 21<br>with a care plan for a triggered CAA and the type(s) of care plan interventions that are appropriate for a particular resident. Documentation may appear anywhere in the clinical record, e.g., progress notes, consults, flowsheets, etc."<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could ensure all residents with a significant change in status would be assessed and referrals to therapy would be completed when appropriate to ensure interventions were initiated to maintain and/or prevent further decline in resident's abilities.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 915 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245580 | A. BUILDING **01 - NURSING HOME 01**<br>B. WING ____________ | **04/14/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKEWOOD CARE CENTER** | **600 MAIN AVENUE SOUTH**<br>**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 |
|---|---|---|---|---|
| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Lakewood Care Center 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>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.<br><br>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.<br><br>IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: | K 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 05/12/2021 |

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245580 | A. BUILDING **01 - NURSING HOME 01**<br>B. WING ______ | **04/14/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKEWOOD CARE CENTER** | **600 MAIN AVENUE SOUTH**<br>**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 |
|---|---|---|---|---|
| K 000 | Continued From page 1<br><br>HEALTH CARE FIRE INSPECTIONS<br>STATE FIRE MARSHAL DIVISION<br>445 MINNESOTA STREET, SUITE 145<br>ST. PAUL, MN 55101-5145, or<br><br>By e-mail to:<br>FM.HC.Inspections@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A detailed description of the corrective action taken or planned to correct the deficiency.<br><br>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.<br><br>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.<br><br>4. Identify who is responsible for the corrective actions and monitoring of compliance.<br><br>5. The actual or proposed date for completion of the remedy.<br><br>Lakewood Care Center is a 1-story building without a basement and with a penthouse. The building was constructed in 2000, was determined to be of Type V (111) construction and is attached to the hospital building which is separated with a 2- hour fire barrier. The facility is divided into 3 smoke zones by 1- hour fire barriers. | K 000 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245580 | A. BUILDING **01 - NURSING HOME 01**<br>B. WING ________ | **04/14/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKEWOOD CARE CENTER** | **600 MAIN AVENUE SOUTH**<br>**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 |
|---|---|---|---|---|
| K 000 | Continued From page 2<br>The building is fully sprinkler protected with a dry pipe sprinkler system and also has a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 32 beds and had a census of 24 at the time of the survey.<br><br>The requirements of 42 CFR, Subpart 483.70(a) are NOT MET. | K 000 | | |
| K 372<br>SS=D | Subdivision of Building Spaces - Smoke Barrie<br>CFR(s): NFPA 101<br><br>Subdivision of Building Spaces - Smoke Barrier Construction<br>2012 EXISTING<br>Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier.<br>19.3.7.3, 8.6.7.1(1)<br>Describe any mechanical smoke control system in REMARKS.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain 1 of 3 smoke barrier walls in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 19.3.7.3, 8.3.5.6, and 8.5.6. This | K 372 | POC. Facilities Maintenance added new fire caulk to holes that caulk had failed. Corrected on 4/16/21. Pm work order for firewall inspection Lakewood Care Center took affect 5/1/2021, Just after the | 4/16/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245580 | A. BUILDING **01 - NURSING HOME 01**<br>B. WING ______ | **04/14/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKEWOOD CARE CENTER** | **600 MAIN AVENUE SOUTH**<br>**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 |
|---|---|---|---|---|
| K 372 | Continued From page 3<br>deficient practice could affect 14 of 32 residents.<br><br>Findings include:<br><br>On 04/14/2021, at 11:55 a.m., observations revealed that there is a 2 inch opening around communication and fire alarm cabling that are passing through the smoke barrier wall above the ceiling tile over cross-corridor doors located the smoke barrier by the dietary office.<br><br>This deficient condition was verified by the Maintenance Supervisor. | K 372 | inspection. Facility Manage, Chris Bowman Confirmed repair. | |
| K 712<br>SS=F | Fire Drills<br>CFR(s): NFPA 101<br><br>Fire Drills<br>Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.<br>19.7.1.4 through 19.7.1.7<br>This REQUIREMENT is not met as evidenced by:<br>Based on documentation review and staff interview, it was determined that the facility failed to conduct 2 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition, sections 19.7.1.2 and 19.7.1.6, during the last 12 months. This deficient practice could affect 32 of 32 residents. | K 712 | POC. Starting 4/17/2021 when closing a work order for fire drills in (Facility 1, CMMS Data base) a required field has been added for a specific fire drill time before closing and attaching work order. Also manual scheduling has been implemented by maintenance staff to help | 4/17/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245580 | A. BUILDING **01 - NURSING HOME 01**<br>B. WING ______ | **04/14/2021** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKEWOOD CARE CENTER** | **600 MAIN AVENUE SOUTH**<br>**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 |
|---|---|---|---|---|
| K 712 | Continued From page 4<br><br>Findings include:<br><br>On 04/14/2021, at 11:10 a.m., during the review of all available fire drill documentation and interview with the Maintenance Supervisor the following deficient conditions were found:<br><br>1. The facility failed to conduct a 2nd shift (evening) fire drill in the 1st quarter within the last 12 month period.<br><br>2. The facility failed to conduct a 2nd shift (evening) fire drill in the 4th quarter within the last 12 month period.<br><br>This deficient condition was confirmed by a Maintenance Supervisor. | K 712 | visualize all the fire drills done yearly. Facility Manager, Chris Bowman will confirm at sign off. | |
| K 901<br>SS=E | Fundamentals - Building System Categories<br>CFR(s): NFPA 101<br><br>Fundamentals - Building System Categories<br>Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel.<br>Chapter 4 (NFPA 99)<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on staff interview and a review of the available documentation, the facility has failed to | K 901 | POC. All patient care equipment repair and preventative maintenance is | 5/18/21 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245580 | A. BUILDING **01 - NURSING HOME 01**<br>B. WING ______ | 04/14/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKEWOOD CARE CENTER** | **600 MAIN AVENUE SOUTH**<br>**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 |
|---|---|---|---|---|
| K 901 | Continued From page 5<br>provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 32 of 32 residents.<br><br>Findings include:<br><br>On 04/14/2021, at 11:15 p.m. during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility could not provide a completed utility risk assessment document at the time of the inspection. The utility risk assessment that was provided at the time of the inspection did not cover patient care equipment as detailed in NFPA 99 "Health Care Facilities Code" 2012 edition Chapter 10 - Electrical Equipment and Chapter 11 - Gas Equipment.<br><br>This deficient condition was verified by the Maintenance Supervisor. | K 901 | performed by the BIO Med department out of St. Josephs Park Rapids. A risk assessment of patient care equipment from them will be added to the Life-Safety book for Long Term Care. Bio-Med Clinical Engineering Manger Patrick Hoffman will review with Facility Manger Chris Bowman 5/18/2021. | |