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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GYTZ

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

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 **08/15/2017** (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 **36** (L18)

13.Total Certified Beds **36** (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 |
|---|---|---|---|---|
| | 36 | | | |
| (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 :
Lyla Burkman, Unit Supervisor 08/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 08/17/2017 (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
**08/17/2017**
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

**PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS**

CMS Certification Number (CCN): 245580 August 17, 2017

Mr. David Nelson, Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN 56623

Dear Mr. Nelson:

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 August 2, 2017 the above facility is certified for or recommended for:

36 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 36 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

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

DEPARTMENT OF HEALTH

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

Electronically delivered August 17, 2017

Mr. David Nelson, Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN 56623

RE: Project Number S5580028

Dear Mr. Nelson:

On July 11, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 23, 2017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On August 15, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 23, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 2, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 23, 2017, effective August 2, 2017 and therefore remedies outlined in our letter to you dated July 11, 2017, will not be imposed.

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

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**

ID: GYTZ

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

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(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 **06/23/2017** (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**

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From (a) :
To (b) :

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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 |
|---|---|---|---|---|
| | 36 | | | |
| (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 :
Debra Vincent, HFE II 07/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/16/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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3. Both of the Above :
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**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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 11, 2017

Mr. David Nelson, Administrator
Lakewood Care Center
600 Main Avenue South
Baudette, MN 56623

RE: Project Number S5580028

Dear Mr. Nelson:

On June 23, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;
>
> Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

**Lyla Burkman, Unit Supervisor**
**Bemidji Survey Team**
**Licensing and Certification Program**
**Health Regulation Division**
**Minnesota Department of Health**
**705 5th Street Northwest, Suite A**
**Bemidji, Minnesota 56601-2933**
**Email: lyla.burkman@state.mn.us**
**Phone: (218) 308-2104**
**Fax: (218) 308-2122**

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 2, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

### Original deficiencies not corrected

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

### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by September 23, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original

statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 23, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

**Fax: (651) 215-0525**

Please contact me if you have questions related to this eNotice.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@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 _____ | 06/23/2017 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>On June 20, 2017, through June 23, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities.<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.<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 241 SS=D | 483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>(a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to transport 1 of 1 resident (R9) in a dignified manner who was observed to be transported down the hallway | F 241 | Lakewood updated care plan with resident R9□s bathing preferences. LakeWood staff unintentionally covered this resident□s face with the bath blanket | 8/2/17 |

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

Electronically Signed | 07/14/2017

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 _____ | 06/23/2017 |

| 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 241 | Continued From page 1<br>suspended in the air with a mechanical lift.<br><br>Findings include:<br><br>R9's quarterly Minimum Data Set (MDS) dated 5/17/17, indicated R9's diagnoses included anxiety, depression, cerebral vascular accident (stroke) and expressive aphasia. R9's cognition was intact and could understand and be understood. R9 was totally dependent on staff for bed mobility, transferring, bathing, and personal hygiene. R9 had functional range of motion impairments on upper and lower extremities bilaterally, and used a wheelchair for locomotion.<br><br>R9's Functional Status Care Area Assessment dated 2/28/17, indicated R9 received total assist with all activities of daily living (ADL's). R9 was wheelchair and bed bound and received total assistance with bed and wheelchair mobility needs.<br><br>R9's care plan dated 6/22/17, indicated a focus area for bathing with a self-care deficit related to R9's CVA. R9 required total assist of two staff members with transfers including into and out of the tub. Another area of focus identified was communication. The interventions indicated that R9 was able to communicate with staff using a communication board and non-verbal communication. In addition, a focus area for transferring was identified due to R9's CVA and left sided weakness. R9's care plan directed staff to utilize the mechanical lift for transfers and the assistance of two staff members.<br><br>On 6/22/17, at 9:16 a.m. nursing assistant (NA)-A and NA-D retrieved the Maxi Move (mechanical lifting device) from the equipment room and after | F 241 | while preparing her for her bath.<br>Lakewood will create a bathing policy that would include specific language addressing appropriate use and placement of bath blankets for dignity and warmth. The policy will be created and education will be provided to the care center nursing staff by DON by August 2, 2017. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. The care center DON will audit any residents who choose to undress in their room prior to going to the tub room to ensures they will be covered appropriately according to policy. Audits will be completed weekly for 1 month, biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.<br>Lakewood, with the assistance of an occupational therapy consult, developed an alternate form of transportation to the tub room with resident R9 on 6/26/17. Staff began using the mechanical lift to transfer the resident to a wheelchair, then wheeled the resident down to the tub room in the wheel chair. Once inside the tub room, the resident was lifted via the mechanical lift into the tub chair. After bathing was completed the resident was transferred via mechanical lift to the wheelchair, then wheeled back to her room, where she was again transferred into her bed. On 6/29/17 the resident indicated to staff that she did not want to be transferred using the new method any longer because it caused her too much pain. Her preference was to be | |

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| F 241 | Continued From page 2<br>NA-A obtained a charged battery for the lift, NA-A and NA-D entered R9's room with the mechanical lift. R9 was observed laying in her bed with a blue mechanical lift sling positioned under her. NA-A positioned the lift over the bed and NA-A and NA-D attached the sling to the hooks on the mechanical lift. NA-A used the mechanical lift remote and raised R9 up off of the bed while NA-D guided R9 and swung R9's lower extremities over the side of the bed. NA-A and NA-D took two sheets and wrapped the sheets around R9 in cocoon fashion. R9's face was fully covered by the top sheet with only R9's top of her head visible and R9's feet dangling from the bottom hem of the sheet. NA-D hooked R9's catheter bag to the side of the sling. NA-A and NA-D proceeded to transport R9, while suspended from the lift and dangling about three feet from the floor out the door and proceeded down the hallway to the tub/shower room which was located approximately 50 feet down the hallway and on the opposite side of the hallway of R9's room. R9 was heard to make moaning and groaning noises all during the transfer down the hallway. NA-D reassured R9 several times that she was going to be okay. NA-D opened the tub/shower room door and NA-A and NA-D guided the mechanical lift which R9 was suspended from into the tub room. R9's face had remained fully covered during this entire transfer. Once inside the tub/shower room NA-A and NA-D guided the lift over the tub, removed the sheets from R9 and filled the tub with water. NA-D exited the room and NA-A proceeded to assist R9 with her bath.<br><br>On 6/22/17, at 9:31 a.m. R9 was observed being transported out of the tub/shower room by NA-A and NA-D. R9 was suspended about three feet | F 241 | transferred via the previous method in a mechanical lift from her room to the tub room and back via mechanical lift. Her medical record and care plan have been updated to reflect her preferences. Lakewood has updated its dignity policy to indicate that the resident will be provided with alternate options for transportation if applicable, risks and benefits of their request/preference will be provided, manufacture□s recommendations (if any) will be reviewed, and any safety concerns will be addressed. In addition, Lakewood will offer resident R9 at each bath time, the choice of transferring with the lift from her room to the tub room or via the newly developed plan including the wheelchair. The updated policy will also signify that resident preferences will be documented in the resident□s medical record and updated in the care plan. Education regarding the updated policy will be provided to the care center nursing staff by DON August 2, 2017. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. During daily report when a resident specific preference is reported, we will audit the record to be sure that preference was documented and care plan has been updated. Audits will be completed weekly for 1 month, biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary. | |

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| F 241 | Continued From page 3 | F 241 | | |

off of the ground, and R9 had bath blankets wrapped around her body with her face exposed. NA-A and NA-D transported R9, while suspended from the mechanical lift, back inter R9's room and next to her bed. The battery on the mechanical lift was not working properly, and R9's bed had to be made. NA-A and NA-D left R9 suspended from the mechanical lift while they made the bed (total of 4 minutes) all the while R9 continued to make groaning and moaning noises. NA-D reassured R9 that she was going to be okay. NA-A and NA-D ended up raising the bed in a higher position in order to safely position R9 and the sling over the bed, lowered R9 back down to a laying positioned and moving R9 from side to side removed the mechanical lift sling.

On 6/22/17, at 11:12 p.m. NA-A confirmed the staff usually used the mechanical lift to transport R9 from her room to the tub room and back.

On 6/22/17, at 11:23 a.m. NA-D confirmed the staff used the mechanical lift to transport R9 from her room to the tub room and back.

On 6/22/17, at 12:33 p.m. registered nurse (RN)-A verified the NA's normally used the mechanical lift to transport R9 from her room to the tub room. RN-A stated she had wondered how safe this was. Licensed practical nurse (LPN)-A commented that the NA's used the lift to transport because they felt putting R9 in the bath chair may cause R9 more discomfort. RN-A estimated it was about 35 feet from R9's room to the tub/shower room. When asked if RN-A felt this was a dignified mode of transport for R9, RN-A stated it does look "horrible".

On 6/22/17 at 1:18 p.m. R9 was interviewed

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| F 241 | Continued From page 4<br>privately in her room. When asked if she felt it was a dignified manner to be transported from her room to the tub/shower room suspended from the mechanical lift and having her face fully covered, R9 shook her head no.<br><br>On 6/22/17, at 1:36 p.m. LPN-A confirmed R9 was able to understand questions and be understood.<br><br>On 6/22/17, at 8:21 a.m. director of nursing (DON) and vice president of patient care services acknowledged that transporting R9 suspended in a sling from a mechanical lift with her face fully covered was not a very dignified manner to transport a resident.<br><br>On 6/23/17, at 8:52 a.m. facilities manager (FM) confirmed the distance from R9's bedside into the tub/shower room was 70 feet and three inches.<br><br>On 6/23/17, at 1:16 p.m. LSW asked R9 if she was bothered by the way she was transferred to the shower room in the mechanical lift, R9 shook her head yes. When the surveyor asked her if she would prefer a different method of transfer so she wouldn't have to be walked down the hallway in the lift, R9 gave a thumbs up.<br><br>Dignity policy dated 5/2017, indicated that each resident should receive hospitable care and services in a manner and in an environment that maintained or enhanced dignity and respect in full recognition of his or her individuality. | F 241 | | |
| F 279 SS=D | 483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>483.20 | F 279 | | 8/2/17 |

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| F 279 | Continued From page 5<br>(d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -<br><br>(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and<br><br>(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).<br><br>(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. | F 279 | | |

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| F 279 | Continued From page 6<br><br>(iv)In consultation with the resident and the resident's representative (s)-<br><br>(A) The resident's goals for admission and desired outcomes.<br><br>(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.<br><br>(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to develop a care plan for dysphagia (difficulty swallowing) that included safe swallowing recommendations for 1 of 3 residents (R20) reviewed for activities of daily living.<br><br>Findings include:<br><br>R20's Face Sheet dated 6/23/17, included diagnoses of history of aspiration pneumonia and dementia.<br><br>R20's quarterly Minimum Data Set (MDS) dated 4/26/17, indicated R20 had severe cognitive impairment with disorganized thinking, had a therapeutic diet, and required supervision of one staff member for eating. | F 279 | Lakewood updated the care plan for resident R20 in regards to speech therapy recommendations. Lakewood will update the care plan policy to include the procedure of updating the resident care plans and the group sheets with necessary recommendations from interdisciplinary team members including speech therapy. The policy will be updated and education will be provided to the care center nursing staff by DON by August 2, 2017. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. The care center DON will audit care plans to ensure updates are recorded. Audits will be completed weekly for 1 month, biweekly for 3 months. The audits will be presented to the IDT QAPI committee for | |

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| F 279 | Continued From page 7<br>R20's nursing progress note dated 1/18/17 indicated R20 had aspirated at breakfast and vomited in copious amounts five or six times for half an hour.<br><br>R20's speech language pathologist (SLP) note dated 1/24/17, indicated R20 had been referred to speech therapy after two episodes of choking with signs and symptoms of aspiration that occurred on 1/18/17 during a meal. The note further indicated R20 had a history of aspiration pneumonia and skilled speech services were warranted at that time to implement safe swallowing strategies in order to reduce the occurrence of coughing and choking episodes and to ensure maximal airway protection.<br><br>R20's nutrition care plan dated 6/23/17, indicated R20 was independent at meals and able to make food preferences known with no potential nutrition risks and required a mechanical soft diet with small portions with a start date of 4/12/17. The oral hygiene care plan with a start date of 3/6/16, indicated R20 had upper and lower dentures and included "Mouth Care-oral care per staff assist." The care plan did not recognize the diagnoses of dysphagia, history or risk for aspiration, or intervention to ensure safe swallowing measures to decrease the risk of choking and aspiration.<br><br>R20's nursing assistant (NA) care guide did not include SLP's recommendations nor identified the risk for aspiration and did not identify the level of assistance R20 required for eating.<br><br>R20's SLP note dated 1/26/17, indicated SLP educated the kitchen staff to ensure food was cut into small bites before serving it to him. | F 279 | 4 months or until determined they are no longer necessary. | |

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| F 279 | Continued From page 8<br>R20's SLP visit note dated 3/1/17, indicated R20 demonstrated prolonged chewing time due to difficulty forming a bolus and had a video swallow that showed notable aspiration below the vocal folds in four out of four swallow attempts with no protective cough or throat clearing present. SLP identified diagnoses of dysphagia, oropharyngeal phase; characterized by difficulty masticating solid materials do to weakness and had consistent aspiration of thin liquids via a cup.<br><br>R20's SLP note dated 3/2/17, informed staff he was ok to have thin water between meals via straw and also ok to have other thin liquids at meals via straw with supervision and verbal reminders to take small sips.<br><br>R20's discharge SLP note dated 3/30/17, indicated R20 had dementia which impacted his ability to remember to use strategies. SLP explained a cue card that directed to slow down, take small bites and sips was placed at his table, which helped his ability to remember, however R20 used those safe strategies with only 80% accuracy. SLP further indicated thin liquid was ok, provide the thin liquid in a cup with a lid to slow down the flow, or with a straw to get his head in chin tuck position, oral hygiene, and limit thin liquids containing sugars and proteins.<br><br>R20's SLP note dated 4/417, indicated nectar thickened liquids had been recommended and trialed during the course of speech treatment however, R20 had been refusing. SLP indicated as a result, it was ok for R20 to have thin liquids while implementing safe swallowing strategies and R20 had the ability to reference a cue card to slow down and take small sips. The SLP also recommended oral hygiene after every meal. | F 279 | | |

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| F 279 | Continued From page 9<br><br>R20's dietary progress note dated 5/1/17, indicated SLP wrote discharge instructions to provide thin liquid in a cup with a lid to slow down the flow, or with a straw to get his head in a chin tuck position and needed to be monitored and encouraged to slow down when eating and drinking to avoid aspiration.<br><br>On 6/21/17, at 12:28 p.m. licensed practical nurse (LPN)- C indicated R20 went from independent with eating to supervision after choking episodes and a speech evaluation. LPN-C reported R20 sat at a table where other residents were assisted, R20 had a cue card where he sat to take small bites and slow down. LPN-C indicated the safe swallowing interventions should be on the care plan.<br><br>-At 6/21/17, R20 stated he swallowed wrong every once in a awhile and coughed occasionally, however didn't have swallowing difficulties. R20 indicated staff did not have to provide verbal cues for swallowing because there was a cue card to tell him that where he sat. R20 stated his nose seemed to run all the time.<br><br>-At 1:05 p.m., NA-B stated staff did not need to directly supervisor R20 during meals, but he did sit in an area where there was more supervision, did not have problems swallowing, and had a regular diet. NA-B was not aware if she had access to the care plan. During a subsequent interview on 6/22/17, at 12:22 p.m., NA-B confirmed staff did not sit by R20 to eat and stated R22 usually had a runny nose after he ate, and it was fine for R20 to drink out of regular cups in the dining room and had a water jug in his room with a straw. | F 279 | | |

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| F 279 | Continued From page 10<br><br>On 6/22/17, at 7:49 a.m. R20 sat at the breakfast table, R20 had a cup of coffee, apple juice, and a cup of water that were thin consistency without straws or lids. R20 also had a sausage link that was not cut up into small pieces. R20 had a runny nose but did not cough during the meal. Staff were observed to be in the general area throughout the meal however, did not sit next to R20 to ensure safe swallowing strategies were followed.<br><br>-At 12:38 p.m. LPN-B stated R20 required supervision with eating and food needed to be cut up. LPN- B reported R20 had problems with swallowing and choking problem.<br><br>On 6/23/17, at 9:15 a.m. vice president of patient care (VP) stated the care plan should have identified R20's swallowing difficulty, the level of assistance required, and the SLP recommendations. VP further indicated the speech therapist was no longer employed with the facility.<br><br>-At 10:51 a.m. registered nurse (RN)-C explained when supervision was coded on the MDS, it meant the supervision was direct and staff were next to the resident and it did not mean staff were in the general location. RN-C stated R20 required supervision during meals.<br><br>-At 12:46 p.m., dietary technician was aware of all of the SLP's recommendations and stated R20 required direct supervision from staff in to ensure R20 followed the safe swallowing strategies and R20's swallowing difficulties and SLP's recommendations should have been added to the care plan. | F 279 | | |

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| F 279 | Continued From page 11 | F 279 | | |
| F 280 SS=D | A facility policy was requested and not received.<br>483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>483.10<br>(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:<br><br>(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.<br><br>(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.<br><br>(iv) The right to receive the services and/or items included in the plan of care.<br><br>(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.<br><br>(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--<br><br>(i) Facilitate the inclusion of the resident and/or resident representative. | F 280 | | 8/2/17 |

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| F 280 | Continued From page 12<br>(ii) Include an assessment of the resident's strengths and needs.<br><br>(iii) Incorporate the resident's personal and cultural preferences in developing goals of care.<br><br>483.21<br>(b) Comprehensive Care Plans<br><br>(2) A comprehensive care plan must be-<br><br>(i) Developed within 7 days after completion of the comprehensive assessment.<br><br>(ii) Prepared by an interdisciplinary team, that includes but is not limited to--<br><br>(A) The attending physician.<br><br>(B) A registered nurse with responsibility for the resident.<br><br>(C) A nurse aide with responsibility for the resident.<br><br>(D) A member of food and nutrition services staff.<br><br>(E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.<br><br>(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. | F 280 | | |

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| F 280 | Continued From page 13<br><br>(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to revise the care plan to include individualized target behaviors and non-pharmacological interventions for the use of antipsychotic medication (Risperdal) for 1 of 5 residents (R10) reviewed for unnecessary medications. In addition, the facility failed to revise the plan of care to include side effects related to use of anticoagulant medication (Coumadin) for 1 of 1 resident (R1) reviewed for unnecessary medication.<br><br>Findings include:<br><br>R10's current Care Planning Report indicated a focus of "Behavior", dated 3/4/13, which indicated R10 had a behavior deficit related to cognitive deficits, wandering, resisting cares, and verbal outbursts/swearing. The Care Plan directed staff to provide healthy snacks/drinks at bedtime or night when he was up looking for snacks, help with adjustment to floor and routine changes, provide verbal reminders related to behavior, speak to R10 calmly and with simple terms, monitor sadness/depression and provide Florentine (antidepressant) 40 mg daily and Risperdal 3 mg at bedtime daily. The Care Plan lacked target behaviors specific to psychosis and corresponding non-pharmacological interventions to address such target behaviors.<br><br>On 6/21/17, at 2:09 p.m. R10 was observed | F 280 | Lakewood updated the care plan of resident R10 to include target behaviors and non-pharmacological interventions. Lakewood will update the psychoactive medications and GDR policy to include a procedure for updating the care plan in regards to target behaviors and non-pharmacological interventions. The policy will be updated and education will be provided to the care center nursing staff by DON by August 2, 2017. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. Audits of documentation and care plan will be completed for any resident on a psychoactive medication. Audits will be completed weekly for 1 month, biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.<br><br>Lakewood updated the care plan of resident R1 to include side effects of anticoagulant medication. Lakewood will update the care plan policy to address residents who are prescribed anticoagulants. The revised policy will be updated and education will be provided to the care center nursing staff by DON by August 2, 2017. Completion will be | |

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| F 280 | Continued From page 14<br>resting in his room, in a recliner, with the foot of the chair elevated. One leg was on the foot rest and one leg was observed hanging dependently. R10 was watching television and displayed no behaviors<br><br>On 6/21/17, at 2:32 p.m. nursing assistant (NA)-F stated R10 required extensive assistance with his activities of daily living and often got angry and swore at staff. NA-F also stated R10 did hallucinate about people in his room and had delusions that he needed to go to work. She indicated R10 may have had more issues on the evening shift. She indicated R10 sometimes wanted to go outside. NA-F stated one to one conversations, walking outside, snacks, and westerns on TV were things that would distract R10 and she indicated they would also call R10's wife if his behavior got bad. NA-F stated she reported any behaviors or mood issues to the nurse who then documented in the electronic medical record.<br><br>On 6/22/17, at 8:30 a.m. R10 was observed to ambulate independently from the dining room to his room. NA-E approached R10 in hall and asked if he could assist him to walk to his chair. Interactions between NA-E and R10 were cordial and pleasant. NA-E spoke in simple direct statements and engaged R10 in conversation. He provided verbal cues to R10 to assist him to his recliner in room. R10 was not observed to exhibit any behaviors.<br><br>On 6/22/17, at 1:39 p.m. registered nurse (RN)-C confirmed R10 received Risperdal for psychosis. RN-C indicated R10 swore at staff, refused cares and could be aggressive. RN-C confirmed the behaviors identified were not individualized for | F 280 | tracked via a sign in sheet and compared to a staff roster with 100% compliance. Audits of care plans will be completed for any resident on an anticoagulation medication. Audits will be completed weekly for 1 month, biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary. | |

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| F 280 | Continued From page 15 | F 280 | | |

psychosis. RN-C also confirmed there was no monitoring of specific target behaviors related to psychosis and non-pharmacological interventions had not been identified for R10's use of Risperdal.

On 6/22/17, at 2:20 p.m. the consulting pharmacist (CP) confirmed R10's record lacked target behaviors and non-pharmacological interventions for the use of Risperdal and indicated it should have been identified and addressed.

The Psychoactive Medication and GDR [gradual dose reduction] policy dated 12/2016, indicated during the care planning process the RN would collect data examining the incidence of target behaviors, current dosage of psychotropic medications, possible side effects noted and ensuring dose reduction has been attempted according to State and Federal Regulations.
R1 received anticoagulant medication (Coumadin) and the care plan lacked identification of monitoring for side effects related to its use.

R1's Diagnosis Listing by Resident form dated 6/23/17, indicated R1 had diagnoses which included anxiety disorder, long term use of anticoagulants, history of pulmonary embolism, panic disorder and risk for falls.

R1's quarterly MDS dated 3/15/17, indicated R1 was cognitively intact, at risk for falls, received antipsychotic, antidepressant, and anticoagulant medications. R1 had received anticoagulant medication six days during the assessment period.

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| F 280 | Continued From page 16<br>R1's Physician Orders report print date 6/21/17, indicated R1 had orders which included Coumadin 1.0 milligrams (mg) on Monday, Wednesday, and Friday evenings, and Coumadin 2.0 mg. on Sunday Tuesday, Thursday and Saturday evening, with start dates of 3/8/17.<br><br>R1's care plan lacked identification of possible side effects or monitoring for side effects related to prescribed Coumadin use.<br><br>On 6/22/2017, at 9:29 a.m. During an an interview with RN-C, director of nursing (DON) and the vice president of nursing services (VP), RN-C confirmed R1's care plan lacked identification of possible side effects and monitoring of anticoagulant medications. RN-C confirmed R1 had falls with injuries, most recent on 6/20/17, with bruising and laceration to forehead and stated the side effect identification and monitoring should have been identified on the care plan.<br><br>The Resident Care Planning Process policy dated 12/2016, indicated the overall plan of care is reviewed and revised quarterly by representatives from all services involved in the care of the individual resident. Each service updates their record system with the changes and additions related to their responsibilities. | F 280 | | |
| F 311 SS=D | 483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS<br><br>(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) | F 311 | | 8/2/17 |

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| F 311 | Continued From page 17<br>of this section.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to provide the recommended level of staff assistance and safe swallowing strategies to ensure safe eating techniques were utilized in order to prevent aspiration for 1 of 3 residents (R20) reviewed for activities of daily living.<br><br>Findings include<br><br>R20's Face Sheet dated 6/23/17, included diagnoses of history of aspiration pneumonia and dementia.<br><br>R20's quarterly Minimum Data Set (MDS) dated 4/26/17, indicated R20 had severe cognitive impairment with disorganized thinking, had a therapeutic diet, and required supervision of one staff member for eating.<br><br>R20's speech language pathologist (SLP) note dated 1/24/17, indicated R20 had been referred to speech therapy after two episodes of choking with signs and symptoms of aspiration that occurred on 1/18/17, during a meal. The note further indicated R20 had a history of aspiration pneumonia and skilled speech services were warranted at that time to implement safe swallowing strategies in order to reduce the occurrence of coughing and choking episodes and to ensure maximal airway protection.<br><br>R20's SLP visit note dated 3/1/17, SLP identified diagnoses of dysphagia, oropharyngeal phase; characterized by difficulty masticating solid materials do to weakness and had consistent | F 311 | Lakewood will update the care plan of resident R20 to reflect recommended level of staff assistance during meals. Lakewood will create a dining room supervision policy that will include specific language addressing degrees of supervision and assistance to be provided by staff based on recommendations from interdisciplinary team. The policy will be created and education will be provided to the care center nursing staff by lead dietary technician by August 2, 2017. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. Dietary technician will perform visual audits of the dining room to validate that the required level of supervision is occurring for resident R20 during meals. Audits will be completed daily for 1 week, weekly for 1 month, biweekly for 3 months. Both audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary. | |

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| F 311 | Continued From page 18<br>aspiration of thin liquids via a cup.<br><br>R20's care plan dated 6/23/17, did not define the level of assistance required for eating and did not recognize the diagnoses of dysphagia, history or risk for aspiration, or intervention to ensure safe swallowing measures to decrease the risk of choking and aspiration.<br><br>R20's SLP note dated 1/26/17, indicated SLP educated the kitchen staff to ensure food was cut into small bites before serving it to him.<br><br>R20's discharge SLP note dated 3/30/17, indicated R20 had dementia which impacted his ability to remember to use strategies. SLP explained a cue card that directed to slow down, take small bites and sips was placed at his table, which helped his ability to remember, however R20 used those safe strategies with only 80% accuracy. SLP further indicated thin liquid was ok, provide the thin liquid in a cup with a lid to slow down the flow, or with a straw to get his head in chin tuck position, oral hygiene, and limit thin liquids containing sugars and proteins.<br><br>R20's dietary progress note dated 5/1/17, indicated SLP wrote discharge instructions to provide thin liquid in a cup with a lid to slow down the flow, or with a straw to get his head in a chin tuck position and needed to be monitored and encouraged to slow down when eating and drinking to avoid aspiration.<br><br>On 6/21/17, at 12:28 p.m. licensed practical nurse (LPN)-C indicated R20 went from independent with eating to supervision after choking episodes and a speech evaluation. LPN-C reported R20 sat at a table where other residents were | F 311 | | |

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| F 311 | Continued From page 19 | F 311 | | |

assisted, R20 had a cue card where he sat to take small bites and slow down. LPN-C indicated the safe swallowing interventions should be on the care plan.

-At 6/21/17, R20 stated he swallowed wrong every once in a awhile, coughed occasionally, however, didn't have swallowing difficulties, and indicated staff did not provide verbal cues for swallowing because there was a cue card to tell him that where he sat. R20 stated his nose seems to run all the time.

-At 1:05 p.m., NA-B stated staff did not need to directly supervisor R20 during meals, but he sat in an area where there was more supervision, did not have problems swallowing, and had a regular diet. NA-B was not aware if she had access to the care plan. During a subsequent interview on 6/22/17, at 12:22 p.m., NA-B confirmed staff did not sit by R20 to eat and stated R22 usually had a runny nose after he ate, and it was fine for R20 to drink out of regular cups in the dining room and had a water jug in his room with a straw.

On 6/22/17, at 7:49 a.m. R20 sat at the breakfast table, R20 had a cup of coffee, apple juice, and a cup of water that were thin consistency without straws or lids. R20 also had a sausage link that that was not cut up. R20 had a runny nose but did not cough during the meal. Staff were observed to be in the general area throughout the meal however, did not sit next to R20 to ensure safe swallowing strategies were followed.

-At 12:38 p.m. LPN-B stated R20 required supervision with eating and food needed to be cut up. LPN- B reported R20 had problems with swallowing and choking problem.

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| F 311 | Continued From page 20<br><br>-At 10:51 a.m. registered nurse (RN)-C explained when supervision was coded on the MDS, it meant the supervision was direct and staff were next to the resident and it did not mean staff were in the general location. RN-C stated R20 required supervision during meals.<br><br>-At 12:46 p.m., dietary technician was aware of all of the SLP's recommendations and stated R20 required direct supervision from staff to ensure R20 followed the safe swallowing strategies, there should have been straws in his liquids, and the food should have been cut up.<br><br>A facility policy was requested and not received. | F 311 | | |
| F 323 SS=D | 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>(d) Accidents.<br>The facility must ensure that -<br><br>(1) The resident environment remains as free from accident hazards as is possible; and<br><br>(2) Each resident receives adequate supervision and assistance devices to prevent accidents.<br><br>(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.<br><br>(1) Assess the resident for risk of entrapment from bed rails prior to installation. | F 323 | | 8/2/17 |

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| F 323 | Continued From page 21<br>(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.<br><br>(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to transport 1 of 1 resident (R9) in a safe manner who was observed to be transported down the hallway in a mechanical lift.<br><br>Findings include:<br><br>R9's quarterly Minimum Data Set (MDS) dated 5/17/17, indicated R9's diagnoses included anxiety, depression, cerebral vascular accident (stroke) and expressive aphasia. R9's cognition was intact and could understand and be understood. R9 was totally dependent on staff for bed mobility, transferring, bathing, and personal hygiene. R9 had functional range of motion impairments on upper and lower extremities bilaterally, and used a wheelchair for locomotion.<br><br>R9's Functional Status Care Area Assessment (CAA) dated 2/28/17, indicated R9 received total assist with all activities of daily living (ADL's). R9 was wheelchair and bed bound and received total assistance with bed and wheelchair mobility needs.<br><br>R9's Fall(s) CAA dated 2/28/17, indicated R9 was non-ambulatory and did not transfer or reposition herself. R9 received total staff assist with transfers and mobility needs. R9 was at risk for falls. | F 323 | Lakewood, with the assistance of an occupational therapy consult, developed an alternate form of transportation to the tub room with resident R9 on 6/26/17. As per OT recommendations, staff began using the mechanical lift to transfer the resident to a wheelchair, then wheeled the resident down to the tub room in the wheel chair. Once inside the tub room, the resident was lifted via the mechanical lift into the tub chair. After bathing was completed the resident was transferred via mechanical lift to the wheelchair, then wheeled back to her room, where she was again transferred into her bed. On 6/29/17 the resident indicated to staff that she did not want to be transferred using the new method any longer because it caused her too much pain. Her preference was to be transferred via the previous method in a mechanical lift from her room to the tub room and back via mechanical lift. The risks and benefits were reviewed with resident R9 and she is still in agreement with using the lift. The manufacturer□s guidelines were reviewed and it did not reveal that transportation in a lift is or is not safe for the mechanical lift. Lakewood contacted the facility Arjo representative and he indicated that the manufacture□s guidelines are very | |

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| F 323 | Continued From page 22<br><br>R9's care plan dated 6/22/17, identified a focus area for transferring due to R9's CVA and left sided weakness. R9's care plan directed staff to utilize the mechanical lift for transfers and the assistance of two staff members. In addition, a focus area for safety was identified related to R9's CVA and left sided weakness. The outcome was that R9 would remain safe in her environment with least use of restraints and free from falls related to injury over the next quarter. The care plan indicated R9 had been assessed to be at risk for falls. A focus area for ambulation was identified. Interventions indicated that R9 was non-ambulatory and used a wheelchair for her primary means of locomotion.<br><br>R9's Risk for Falls Questionnaire dated 5/16/17, indicated R9 was at risk for falls.<br><br>On 6/22/17, at 9:16 a.m. nursing assistant (NA)-A and NA-D retrieved the Maxi Move (mechanical lifting device) from the equipment room and after NA-A obtained a charged battery for the lift, NA-A and NA-D entered R9's room with the mechanical lift. R9 was observed laying in her bed with a blue mechanical lift sling positioned under her. NA-A positioned the lift over the bed and NA-A and NA-D attached the sling to the hooks on the mechanical lift. NA-A used the mechanical lift remote and raised R9 up off of the bed while NA-D guided R9 and swung R9's lower extremities over the side of the bed. NA-A and NA-D took two sheets and wrapped the sheets around R9 in cocoon fashion. R9's face was fully covered by the top sheet with only R9's top of her head visible and R9's feet dangling from the bottom hem of the sheet. NA-D hooked R9's catheter bag to the side of the sling. NA-A and | F 323 | specific to exclude transportation in a lift as an appropriate or in appropriate use. He indicated that facility policy would dictate use of lifts including their use for dignity and safety. The medical record and care plan have been updated to reflect resident R9□s preferences in relation to her resident□s rights. Lakewood will update its mechanical lift policy to include language indicating that mechanical lifts are primarily used in transfers within the resident room. It will also include language to indicate when other deviations, such as falls, occur outside of a resident□s room are appropriate to use the lift outside of the room for transport of a resident. The policy will be updated and education will be provided to the care center nursing staff by DON by August 2, 2017. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. Audits of care plans will be completed for any resident who utilizes a mechanical lift for transfers. Audits for compliance with the policy will be completed weekly on the resident□s bath days (2 times per week) for 1 month, biweekly for 3 months. In addition, for the first full month, resident R9 will be asked prior to each bath, her preference for transport to the tub room. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary. | |

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| F 323 | Continued From page 23<br>NA-D proceeded to transport R9, suspended from the lift and dangling about three feet from the floor; took a right out of the door way; and proceeded down the hallway to the tub/shower room which was located approximately 50 feet down the hallway and on the opposite side of the hallway of R9's room. R9 made moaning and groaning noises all during the transfer down the hallway. NA-D reassured R9 several times that she was going to be okay. NA-D opened the tub/shower room door and NA-A and NA-D guided the mechanical lift which R9 was suspended from into the tub room. R9's face had remained fully covered during this entire transfer. Once inside the tub/shower room NA-A and NA-D guided the lift over the tub, removed the sheets from R9 and filled the tub with water. NA-D exited the room and NA-A proceeded to assist R9 with her bath.<br><br>On 6/22/17, at 9:31 a.m. R9 was observed being transported out of the tub/shower room by NA-A and NA-D. R9 was suspended about three feet off of the ground, and R9 had bath blankets wrapped around her body with her face exposed. NA-A and NA-D transported R9, while suspended from the mechanical lift, back inter R9's room and next to her bed. The battery on the mechanical lift was not working properly, and R9's bed had to be made. NA-A and NA-D left R9 suspended from the mechanical lift while they made the bed (total of 4 minutes) all the while R9 continued to make groaning and moaning noises. NA-D reassured R9 that she was going to be okay. NA-A and NA-D ended up raising the bed in a higher position in order to safely position R9 and the sling over the bed, lowered R9 back down to a laying positioned and moving R9 from side to side removed the mechanical lift sling. | F 323 | | |

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| F 323 | Continued From page 24<br><br>On 6/22/17, at 11:12 p.m. NA-A confirmed the staff usually used the mechanical lift to transport R9 from her room to the tub room and back.<br><br>On 6/22/17, at 11:23 a.m. NA-D confirmed the staff used the mechanical lift to transport R9 from her room to the tub room and back.<br><br>On 6/22/17, at 12:33 p.m. registered nurse (RN)-A verified the NA's normally used the mechanical lift to transport R9 from her room to the tub room. RN-A stated she had wondered how safe this was. Licensed practical nurse (LPN)-A commented that the NA's used the lift to transport because they felt putting R9 in the bath chair may cause R9 more discomfort. RN-A estimated it was about 35 feet from R9's room to the tub/shower room.<br><br>On 6/22/17 at 1:18 p.m. R9 was interviewed privately in her room. When asked if she felt safe being transported suspended from the mechanical lift, R9 shook her head no and nonverbally R9's eye's widened. When asked if she felt afraid she would fall when being transported suspended in the mechanical lift, R9 shook her head yes. When asked if she had ever fallen from the mechanical lift, R9 shook her head no.<br><br>On 6/22/17, at 1:36 p.m. LPN-A confirmed R9 was able to understand questions and be understood.<br><br>On 6/22/17, at 8:21 a.m. director of nursing (DON) and vice president of patient care services (VP) were interviewed. DON confirmed R9 was | F 323 | | |

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non-ambulatory and her primary mode of transporting was her wheelchair. VP stated that she could not say that transporting a resident about 30 feet suspended in a mechanical lift was unsafe. DON was not aware of any falls from a mechanical lift. DON confirmed R9 was the only resident on that wing that used that type of mechanical lift.

On 6/23/17, at 8:52 a.m. facilities manager (FM) confirmed the distance from R9's bedside into the tub/shower room was 70 feet and three inches.

Transfer of Resident/Safe Patient Handling policy dated 12/2016, indicated the facility would provide a safe working environment for residents. The facility would work to provide physical and mechanical assistance to all residents unable to bear weight and/or who needed some physical assistance to transfer or move. This policy included the procedure to transfer a resident with a Maxi Lift (mechanical lift) however, the policy lacked identifying if the Maxi Lift could safely be used to transport residents.

Maxi Move (mechanical lift) operating and product care instructions manual dated 5/2008, indicated the Maxi Move was a mobile, passive lift. The Maxi Move manual provided instructions for staff on how to lift a resident from a chair, lift from a bed, lift from the floor, use the stretcher frame, repositioning a resident and how to use the built-in scale. The Maxi Move was identified as a device that would gain a safer, more efficient solution for the basic tasks of patient handling - lifting and repositioning. However, the manual lacked identifying this lifting and transferring device as a device that could safety be used for transporting residents.

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| F 329 SS=D | 483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>483.45(d) Unnecessary Drugs-General.<br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--<br><br>(1) In excessive dose (including duplicate drug therapy); or<br><br>(2) For excessive duration; or<br><br>(3) Without adequate monitoring; or<br><br>(4) Without adequate indications for its use; or<br><br>(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or<br><br>(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.<br><br>483.45(e) Psychotropic Drugs.<br>Based on a comprehensive assessment of a resident, the facility must ensure that--<br><br>(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;<br><br>(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; | F 329 | | 8/2/17 |

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| F 329 | Continued From page 27<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure tapering of an antianxiety medication was attempted or appropriate contraindications to tapering were documented for 1 of 1 resident (R3) who had received an as needed (PRN) antianxiety medication. The facility also failed to ensure an appropriate diagnosis was identified for use of an antipsychotic medication for 1 of 4 resident (R28) and failed to ensure baseline Tardive Dyskinesia monitoring was implemented prior to the initiation of an antipsychotic medication for 1 of 4 resident (R28) who received an antipsychotic medication. Lastly, the facility failed to identify individualized target behaviors and non-pharmacological interventions for the use of an antipsychotic medication for 1 of 4 residents (R10) who received antipsychotic medication.<br><br>Findings include:<br><br>R3 received antianxiety medication (Ativan) without documentation of an attempt to taper or appropriate contraindication identified for tapering the medication.<br><br>R3's Diagnosis Listing By Resident form dated 6/23/17, indicated R3 had diagnoses which included anxiety, insomnia, dizziness and giddiness.<br><br>R3's quarterly Minimum Data Set (MDS) dated 5/31/17, indicated R3 had severe cognitive impairment, symptoms of delirium which included inattentiveness and disorganized thinking, delusions, wandering behavior, and R3 had received antianxiety medication two days during | F 329 | Lakewood will assess resident R3 in regards to tapering of PRN antianxiety medication. Lakewood will update psychoactive medication and GDR policy to include monitoring PRN psychoactive medications. This policy update and education will be provided by consulting pharmacist to nursing staff and medical providers, by August 2, 2017. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. Audits of compliance of the policy will be completed for any resident who is prescribed a PRN psychoactive medications. Audits will be completed weekly for 1 month, biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.<br><br>Lakewood updated the diagnosis for resident R28 in relation to his antipsychotic medication. Lakewood will be providing education to licensed nursing staff and medical providers on the Psychoactive medication and GDR policy which includes the expectation for correct diagnosis with the use of psychoactive medications. This policy review and education will be provided by consulting pharmacist, by August 2, 2017. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. Audits of compliance of the policy will be completed for any resident who is prescribed a psychoactive | |

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| F 329 | Continued From page 28<br>the assessment period.<br><br>R3's Psychotropic Medication Use Care Area Assessment (CAA) dated 9/27/16, indicated R3 was taking an antianxiety medication. R3 was independent with mobility needs and had periods of anxiety and restlessness related to not being around her daughter or family. R3 was medicated with a PRN antianxiety medication or non-pharmacological interventions implemented.<br><br>R3's Physician Order report print date 6/23/17, indicated R3 had medication orders which included Ativan 0.25 milligrams (mg) twice a day PRN with a start date for this medication documented as 10/28/15.<br><br>R3's Care Plan dated 6/22/17, identified a focus area of behavior which indicated R3 had a history of anxiety and depression. The care plan directed staff to administer Ativan 0.25 mg PRN twice a day. Non-pharmacological interventions listed included 1:1 visits, sit with resident if anxious or in need of TLC to reduce wandering, falling and anxiety.<br><br>R3's medication administration records for May 2017, and June 2017, indicated R3 had received prn Ativan 0.25 mg with target behaviors identified and non-pharmacological interventions listed on:<br><br>- 6/4/17, at 7:05 a.m.<br>- 5/29/17, at 9:00 a.m.<br>- 5/25/17, at 7:45 a.m.<br>- 5/24/17, at 2:00 p.m.<br>- 5/23/17, at 12:50 p.m.<br>- 5/22/17, at 11:00 a.m.<br>- 5/20/17, at 1:54 p.m. | F 329 | medications. Audits will be completed weekly for 1 month, biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.<br><br>Lakewood will complete a tardive dyskinesia assessment on resident R28. Lakewood will be providing education to licensed nursing staff on the Tardive dyskinesia monitoring guidelines policy which outlines the assessment timeline associated with residents on psychoactive medications that have the possible side effect of tardive dyskinesia. This policy review and education will be provided by DON, by August 2, 2017. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. Audits of compliance of the policy will be completed for any resident who is prescribed a psychoactive medication with side effect of tardive dyskinesia. Audits will be completed weekly for 1 month, biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.<br>Lakewood will update the care plan of resident R10 to include target behaviors and non-pharmacological interventions for the use of antipsychotic medication.<br>Lakewood will update the psychoactive medications and GDR policy to include a procedure for updating the care plan in regards to target behaviors and non-pharmacological interventions. The | |

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| F 329 | Continued From page 29<br>On 6/21/17, at 2:30 p.m. R3 was observed seated in the dining/activity area participating in a group activity. In the middle of the activity at 2:45 p.m., R3 stood up, grabbed her walker and proceeded to make her way out of the activity area. Nursing assistant (NA)-A immediately went to R3's side and escorted R3 back to her room and assisted R3 into her recliner.<br><br>On 6/22/17, at 7:04 a.m. R3 was observed sleeping in bed, appeared comfortable with eyes closed and easy breathing noted.<br><br>On 6/22/17, at 11:34 a.m. R3 was seated in the dining area, well groomed, alert, and interacted with her tablemates.<br><br>Review of the R3's Pharmacy Reviews form indicated a pharmacist had reviewed R3's medication regimen monthly. On 1/25/17, the pharmacist recommended an update for a tapering for Ativan. On 2/27/17, the pharmacist reiterated the recommendation for the needed update for a tapering for Ativan. On 3/27/17, the pharmacist indicated no recommendations for a tapering of the Ativan as it was a prn medication.<br><br>Gradual Dose Reduction Review forms dated 10/4/16, through 2/9/17, lacked pharmacy recommendations from the pharmacist or nursing regarding a tapering of the prn Ativan.<br><br>Review of R3's physician notes from 12/15/16, to present revealed the following:<br><br>- On 6/13/17, R3 had been on Zoloft (antidepressant) which had not been helping as her symptoms were more for anxiety than depression at this time. The plan indicated R3's | F 329 | policy will be updated and education will be provided to the care center nursing staff by DON by August 2, 2017. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. Audits of documentation and care plan will be completed for any resident on a psychoactive medication. Audits will be completed weekly for 1 month, biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary. | |

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| F 329 | Continued From page 30<br>Zoloft would be tapered and discontinued over a two week period.<br><br>No recommendations regarding tapering Ativan or rationale for continued use were made by the physician.<br><br>On 6/22/17, at 2:20 p.m. during an interview with registered nurse (RN)-C, director of nursing (DON), social worker (SW) and vice president of patient care (VP), RN-C confirmed R3's prn Ativan had not been tapered and justification for not tapering had not been documented because it was the facility's practice to not review the need for tapering of any prn medication.<br><br>Psychoactive Medication and GDR policy, dated 12/2016, indicated the facility would monitor mood altering medications to maintain regulatory compliance with the Minnesota Department of Health (MDH) standards set forth for GDR. In addition, the GDR/tapering for antipsychotic and psychopharmacological medications would be: within the 1st year, twice in two separate quarters with at least one month between attempts; after the first year, once per year, unless clinically contraindicated.<br><br>On 6/22/17, at 2:43 p.m. SW confirmed the facility's current Psychoactive Medication and GDR (gradual dose reduction) policy did not exclude prn medications from being reviewed for the need for a GDR/tapering.<br>R28 received antipsychotic medication (Seroquel) and the clinical record lacked an appropriate diagnosis for use. In addition, the record lacked a baseline tardive dyskinesia (TD) assessment following initiation of an antipsychotic medication (Seroquel). | F 329 | | |

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| F 329 | Continued From page 31<br><br>R28's Diagnosis Listing by Resident form dated 6/23/17, indicated R28 had diagnoses which included malignant neoplasm of prostate and bone, vascular dementia without behavioral disturbances, progressive supranuclear ohthalmoplegia (uncommon brain disorder that affects movement, control of walking (gait) and balance, speech, swallowing, vision, mood and behavior, and thinking).<br><br>R28's admission MDS dated 3/28/17, indicated R28 was severely cognitively impaired, did not received antipsychotic medications. R28 required extensive assist for transfers and was at risk for falls.<br><br>R28's Physician Orders report print date 6/21/17, indicated R28 had orders which included Seroquel 12.5 mg at hours of sleep, Start date-5/23/17 for vascular dementia without/ behavioral disturbances.<br><br>R28's Informed Consent for the administration of psychotropic medications form, dated 5/21/17, for use of Seroquel 12.5 mg. twice daily, indicated the medication prescribed does include the possible side effect of Tardive Dyskinesia.<br><br>On 6/22/17, at 1:28 p.m. RN-C confirmed R28's diagnosis of dementia without behavioral disturbances was not an appropriate diagnosis for use an antipsychotic medication. RN-C confirmed R28's clinical record lacked a baseline TD assessment related to Seroquel use and stated a TD assessment was not done.<br><br>On 6/22/17, at 1:34 p.m. the consulting pharmacist (CP) confirmed R28's diagnosis of | F 329 | | |

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dementia without behavioral disturbances was not an appropriate diagnosis for the use of Seroquel and a baseline TD assessment should have been completed at the initiation of R28's use of Seroquel.

On 6/23/2017, at 9:29 a.m. the DON confirmed R28's diagnosis for his antipsychotic medication was not appropriate. The DON further confirmed a baseline TD assessment should have been completed.

The facility Tardive Dyskinesia Monitoring Guidelines policy, reviewed 11/15, indicated an assessment ratings using the DISCUS (TD assessment) will be completed prior to the initiation of a neuroleptic or antipsychotic medication.

The facility Psychoactive Medication policy, revised 12/16, indicated registered nursing staff will identify and review all psychotropic medications ordered. Current diagnosis will be reviewed for appropriateness with State And Federal Guidelines for the use of psychotropic medications.

R10 received antipsychotic medication (Risperdal) and the record lacked individualized target behaviors and non-pharmacological interventions for its use.

R10's quarterly MDS dated 4/26/17, indicated R10 had moderate cognitive impairment and diagnoses which included cerebral infarction (stroke), depression, and psychotic disorder. The MDS also indicated R47 experienced no mood symptoms, psychosis, behavioral symptoms, rejection of care, or wandering and received

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antipsychotic medication daily during the assessment period.

R10's Behavioral Symptoms CAA dated 2/7/17, indicated R10 had a history of behavior problems, unexplained behavior and unpredictable behavior at times. The CAA also indicated R10 currently yelled out for people to bring him food or yelled "I'm hungry". The CAA further indicated other residents were not aware of R10's behavior due to his lethargic and flat personality and indicated the behaviors occurred in R10's room.

R10's Psychotropic Medication Use CAA dated 2/7/17, indicated R10 was alert but disoriented to time and place. The CAA indicated R10 ambulated independently with the use of a wheeled walker but needed cues to destinations. The CAA further indicated R10 attempted to leave the building due to confusion level and was redirected by staff. R10 received assistance from staff with bed mobility and transfers. He had an alarm in his recliner chair to alert staff to self-transfers and for safety and was at risk for falls due to his cognition.

R10's Physician Orders dated 6/14/17, included an order for Risperdal (antipsychotic) 2 milligrams (mg) one tablet at bedtime for severe depression with psychosis. The order start date was 2/18/14. R10's Medication Administration Records for April, May and June 2017, indicated R10 received Risperdal 2 mg at bedtime daily.

R10's current Care Planning Report indicated a focus of "Behavior", dated 3/4/13, which indicated R10 had a behavior deficit related to cognitive deficits, wandering, resisting cares, and verbal outbursts/swearing. The Care Plan directed staff

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to provide healthy snacks/drinks at bedtime or night when he was up looking for snacks, help with adjustment to floor and routine changes, provide verbal reminders related to behavior, speak to R10 calmly and with simple terms, monitor sadness/depression and provide Florentine (antidepressant) 40 mg daily and Risperdal 3 mg at bedtime daily. The Care Plan lacked target behaviors specific to psychosis and corresponding non-pharmacological interventions to address such target behaviors.

On 6/21/17, at 2:09 p.m. R10 was observed resting in his room, in a recliner, with the foot of the chair elevated. R10 was watching television and displayed no behaviors

On 6/21/17, at 2:32 p.m. nursing assistant (NA)-F stated R10 required extensive assistance with his activities of daily living and often got angry and swore at staff. NA-F also stated R10 did hallucinate about people in his room and had delusions that he needed to go to work. She indicated R10 may have had more issues on the evening shift. She indicated R10 sometimes wanted to go outside. NA-F stated one to one conversations, walking outside, snacks, and westerns on TV were things that would distract R10 and she indicated they would also call R10's wife if his behavior got bad. NA-F stated she reported any behaviors or mood issues to the nurse who then documented in the electronic medical record.

On 6/22/17, at 8:30 a.m. R10 was observed to ambulate independently from the dining room to his room. NA-E approached R10 in the hall and asked if he could assist him to walk to his chair. Interactions between NA-E and R10 were cordial

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and pleasant. NA-E spoke in simple direct statements and engaged R10 in conversation. He provided verbal cues to R10 to assist him to his recliner in room. R10 was not observed to exhibit any behaviors.

R10's Pharmacy Reviews dated 7/29/16 through 5/30/17, indicated R10's medications were reviewed monthly and pharmacist recommendations/comments included but were not limited to the following:

8/28/16: patient current psychiatric medications ok with attempted gradual dose reduction resulting in failure as patient had adverse reactions from this. The pharmacist reviews lacked recommendations regarding target behaviors and non-pharmacological interventions for the use of Risperdal.

The facility mood and behavior monitoring for R10 was reviewed with RN-C, the DON, VP and SW. The Questionnaire History dated 3/1/17, to 6/22/17, revealed the following:

March - behavior issues x 1 shift, specific behavior was not identified
April - no behavior issues
May - behavior issues x 2 shifts, behaviors included: repetitive verbalization, change in usual sleep pattern, repetitive physical movements.
June - behavior issues x 2 shifts, behaviors included: repetitive questions, repetitive verbalization, persistent anger with self/others x 2, complains repetitively about health, repetitive physical movements

On 6/22/17, at 1:39 p.m. RN-C confirmed R10 received Risperdal for psychosis. RN-C indicated

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| F 329 | Continued From page 36<br>R10 swore at staff, refused cares and could be aggressive. RN-C confirmed the behaviors identified were not individualized for psychosis. RN-C also confirmed there was no monitoring of specific target behaviors related to psychosis and non-pharmacological interventions had not been identified for R10's use of Risperdal.<br><br>On 6/22/17, at 2:20 p.m. the CP confirmed R10's record lacked target behaviors and non-pharmacological interventions for the use of Risperdal and indicated it should have been identified and addressed.<br><br>The Psychoactive Medication and GDR [gradual dose reduction] policy dated 12/2016, indicated target behaviors would be identified, monitored and recorded on each shift for medications falling under the category of antipsychotic. The policy did not address ongoing use of non-pharmacological interventions with the use of antipsychotic medication. | F 329 | | |
| F 428 SS=D | 483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON<br><br>c) Drug Regimen Review<br><br>(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.<br><br>(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:<br><br>(i) Anti-psychotic; | F 428 | | 8/2/17 |

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| F 428 | Continued From page 37<br>(ii) Anti-depressant;<br>(iii) Anti-anxiety; and<br>(iv) Hypnotic.<br><br>(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon.<br><br>(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.<br><br>(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified.<br><br>(iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.<br><br>(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document | F 428 | Lakewood consulting pharmacist will | |

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| F 428 | Continued From page 38<br>review, the consulting pharmacist (CP) failed to ensure a tapering of an antianxiety medication was attempted or appropriate contraindications for a tapering was documented for 1 of 1 resident (R3) who had received an as needed (PRN) antianxiety medication. The CP also failed to ensure appropriate diagnosis was identified for use of an antipsychotic medication for 1 of 4 resident (R28) and failed to ensure baseline Tardive Dyskinesia monitoring was implemented prior to the initiation of an antipsychotic medication for 1 of 4 residents (R28) who received an antipsychotic medication. In addition, the CP failed to identify a lack of target behaviors and non-pharmacological interventions for the use of an antipsychotic medication for 1 of 4 residents (R10) who received antipsychotic medication.<br><br>Findings include:<br><br>R3 received an antianxiety medication (Ativan) and the pharmacist failed to identify the lack of appropriate documentation for a tapering or contraindication of tapering the PRN antianxiety medication.<br><br>R3's Diagnosis Listing By Resident form dated 6/23/17, indicated R3 had diagnoses which included anxiety, insomnia, dizziness and giddiness.<br><br>R3's quarterly Minimum Data Set (MDS) dated 5/31/17, indicated R3 had severe cognitive impairment, symptoms of delirium which included inattentiveness and disorganized thinking, delusions, wandering behavior, and R3 had received antianxiety medication two days during the assessment period. | F 428 | review resident R3□s medical record in regards to tapering of PRN antianxiety medication. Lakewood will update psychoactive medication and GDR policy to include monitoring PRN psychoactive medications. This policy update will and education will be provided by consulting pharmacist to nursing staff and medical providers, by August 2, 2017. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. Audits of compliance of the policy will be completed for any resident who is prescribed a PRN psychoactive medications. Audits will be completed weekly for 1 month, biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.<br><br>Lakewood consulting pharmacist will review resident R28□s medical record in regards to correct diagnosis for use with antipsychotic medication. Lakewood will be providing education to licensed nursing staff and medical providers on the Psychoactive medication and GDR policy which outlines correct diagnosis for the use of psychoactive medications must be indicated in the medical record. This policy review and education will be provided by consulting pharmacist, by August 2, 2017. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. Audits of compliance of the policy will be completed for any resident who is prescribed a psychoactive medication. | |

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| F 428 | Continued From page 39<br><br>R3's Psychotropic Medication Use Care Area Assessment (CAA) dated 9/27/16, indicated R3 was taking an antianxiety medication. R3 was independent with mobility needs and had periods of anxiety and restlessness related to not being around her daughter or family. R3 was medicated with a PRN antianxiety medication or non-pharmacological interventions.<br><br>R3's Physician Order report print date 6/23/17, indicated R3 had medication orders which included Ativan 0.25 milligrams (mg) twice a day PRN with a start date for this medication documented as 10/28/15.<br><br>R3's medication administration records for May 2017, and June 2017, indicated R3 had received prn Ativan 0.25 mg on (target behaviors identified and non-pharmacological interventions listed):<br><br>- 6/4/17, at 7:05 a.m.<br>- 5/29/17, at 9:00 a.m.<br>- 5/25/17, at 7:45 a.m.<br>- 5/24/17, at 2:00 p.m.<br>- 5/23/17, at 12:50 p.m.<br>- 5/22/17, at 11:00 a.m.<br>- 5/20/17, at 1:54 p.m.<br><br>On 6/21/17, at 2:30 p.m. R3 was observed seated in the dining/activity area participating in a group activity. In the middle of the activity at 2:45 p.m., R3 stood up, grabbed her walker and proceeded to make her way out of the activity area. Nursing assistant (NA)-A immediately went to R3's side and escorted R3 back to her room and assisted R3 into her recliner.<br><br>On 6/22/17, at 7:04 a.m. R3 was observed | F 428 | Audits will be completed weekly for 1 month, biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.<br><br>Lakewood□ consulting pharmacist will ensure tardive dyskinesia assessment has been completed on resident R28. Lakewood will be providing education to licensed nursing staff on the Tardive dyskinesia monitoring guidelines policy which outlines the assessment timeline associated with residents on psychoactive medications that have the possible side effect of tardive dyskinesia. This policy review and education will be provided by DON, by August 2, 2017. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. Audits of compliance of the policy will be completed for any resident who is prescribed a psychoactive medication with side effect of tardive dyskinesia. Audits will be completed weekly for 1 month, biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.<br>Lakewood□s consulting pharmacist will ensure resident R10□s care plan has been updated to include target behaviors and non-pharmacological interventions for the use of antipsychotic medication. Lakewood will update the psychoactive medications and GDR policy to include a procedure for updating the care plan in regards to target behaviors and | |

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| F 428 | Continued From page 40<br>sleeping in bed, appeared comfortable with eyes closed and easy breathing noted.<br><br>On 6/22/17, at 11:34 a.m. R3 was seated in the dining area, well groomed, alert, and interacted with her tablemates.<br><br>Review of the R3's Pharmacy Reviews form indicated a pharmacist had reviewed R3's medication regimen monthly. On 1/25/17, the pharmacist recommended an update for a tapering for Ativan. On 2/27/17, the pharmacist reiterated the recommendation for the needed update for a tapering for Ativan. On 3/27/17, the pharmacist indicated no recommendations for a tapering of the Ativan as it was a prn medication.<br><br>Gradual Dose Reduction Review forms dated 10/4/16, through 2/9/17, lacked pharmacy recommendations from the pharmacist or nursing regarding a tapering of the prn Ativan.<br><br>Review of R3's physician notes from 12/15/16, to present revealed the following:<br><br>-6/13/17, R3 had been on Zoloft (antidepressant) which had not been helping as her symptoms were more for anxiety than depression at this time. The plan indicated R3's Zoloft would be tapered and discontinued over a two week period.<br><br>No recommendations regarding tapering Ativan or rationale for continued use were made by the physician.<br><br>On 6/22/17, at 2:00 p.m. consulting pharmacist (CP) confirmed R3 has been taking the PRN Ativan 0.25 mg since 10/28/15. CP stated the facility usually reviewed medications which | F 428 | non-pharmacological interventions. The policy will be updated and education will be provided to the care center nursing staff by DON by August 2, 2017. Completion will be tracked via a sign in sheet and compared to a staff roster with 100% compliance. Audits of documentation and care plan will be completed for any resident on a psychoactive medication. Audits will be completed weekly for 1 month, biweekly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary.<br>In addition to the above, Lakewood will also be developing a policy on the pharmacy review process. This policy will be reviewed at the next QAPI meeting on Friday July 21, 2017 or the August meeting based upon acceptance date for this plan of corrections. | |

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required a gradual dose reduction (GDR) every six months to assure that it was addressed at least annually. CP confirmed R3 had not had a GDR nor had a GDR been addressed since R3 had started on this medication on 10/28/15. CP stated he had been instructed by the past nursing leadership staff that any PRN medication was not required to be reviewed for GDR/tapering. However, CP stated that's a "good question" of why PRN medications would be exempt from GDR/tapering review. CP confirmed R3's PRN Ativan should have been reviewed for a GDR/tapering and if still needed contraindications documented for continued use.

On 6/22/17, at 2:20 p.m. registered nurse (RN)-C, in an interview with RN-C, director of nursing (DON), social worker (SW) and vice president of patient care (VP), confirmed R3's prn Ativan had not been tapered or justification for not tapering the prn Ativan documented because it was the facility's practice to not review the need for tapering of any prn medication.

On 6/22/17, at 2:43 p.m. SW confirmed the facility's current Psychoactive Medication and GDR policy did not exclude prn medications from being reviewed for the need for a GDR/tapering.

Psychoactive Medication and GDR policy, dated 12/2016, indicated the facility would monitor mood altering medications to maintain regulatory compliance with the Minnesota Department of Health (MDH) standards set forth for GDR. GDR's would be monitored by the CP each month during medication review of each resident. Recommendations for psychotropic medication review or reduction would be made via a monthly report and communicated on a form (Gradual

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Dose Reduction Review). In addition, the GDR/tapering for antipsychotic and psychopharmacological medications would be: within the 1st year, twice in two separate quarters with at least one month between attempts; after the first year, once per year, unless clinically contraindicated.

R28 received antipsychotic medication (Seroquel) the clinical record lacked an appropriate diagnosis for use. In addition, the record lacked a baseline TD assessment following initiation of an antipsychotic medication.

R28's Diagnosis Listing by Resident form dated 6/23/17, indicated R28 had diagnoses which included malignant neoplasm of prostate and bone, vascular dementia without behavioral disturbances, progressive supranuclear ohthalmoplegia (uncommon brain disorder that affects movement, control of walking (gait) and balance, speech, swallowing, vision, mood and behavior, and thinking).

R28's admission Minimum Data Set (MDS) dated 3/28/17, indicated R28 was severely cognitively impaired, did not receive antipsychotic medications. R28 required extensive assist for transfers and was at risk for falls.

R28's Physician Orders report print date 6/21/17, indicated R28 had orders which included Seroquel 12.5 mg at hours of sleep, Start date-5/23/17, for vascular dementia without/ behavioral disturbances.

R28's Informed Consent for the administration of psychotropic medications form, dated 5/21/17, for use of Seroquel 12.5 mg. twice daily, indicated

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| F 428 | Continued From page 43<br>the medication prescribed does include the possible side effect of Tardive Dyskinesia.<br><br>R28's Pharmacy Reviews dated 5/30/17, indicated currently being monitor for pain due to prostate cancer. The review lacked identification of an inappropriate diagnosis for the use of R28's antipsychotic (Seroquel) medication and lacked identification of a TD assessment regarding psychotropic medication use.<br><br>On 6/22/17, at 1:28 p.m. RN-C confirmed R28's diagnosis of Dementia without behavioral disturbances was not an appropriate diagnosis for use an antipsychotic medication. RN-C confirmed R28's clinical record lacked an baseline TD assessment related to R28's. RN-C confirmed the TD assessment was not done.<br><br>On 6/22/17, at 1:34 p.m. the CP confirmed R28's diagnosis of Dementia without behavioral disturbances was not an appropriate diagnosis for the use of Seroquel and a baseline TD assessment should have been completed at the initiation of R28's use of Seroquel.<br><br>On 6/23/2017, at 9:29 a.m. the DON confirmed R28's diagnosis for his antipsychotic medication was not appropriate. The DON further confirmed a baseline TD assessment should have been completed.<br><br>The facility Tardive Dyskinesia Monitoring Guidelines policy, reviewed 11/15, indicated an assessment ratings using the DISCUS (TD assessment) will be completed prior to the initiation of a neuroleptic or antipsychotic medication. | F 428 | | |

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The facility Psychoactive Medication policy, revised 12/16, indicated registered nursing staff will identify and review all psychotropic medications ordered. Current diagnosis will be reviewed for appropriateness with State And Federal Guidelines for the use of psychotropic medications. the facility routinely monitors the need for psychotropic medications and to monitor the effectiveness of the medications as well as for medication side effects including Tardive Dyskinesia. Staff responsible included Nursing, Medical Provides and Consultant Pharmacist.

R10 received Risperdal (antipsychotic medication) and the CP failed to identify a lack of target behaviors and non-pharmacological interventions for its use.

R10's quarterly MDS dated 4/26/17, indicated R10 had moderate cognitive impairment and diagnoses which included cerebral infarction (stroke), depression, and psychotic disorder. The MDS also indicated R47 experienced no mood symptoms, psychosis, behavioral symptoms, rejection of care, or wandering and received antipsychotic medication daily during the assessment period.

R10's Behavioral Symptoms CAA dated 2/7/17, indicated R10 had a history of behavior problems, unexplained behavior and unpredictable behavior at times. The CAA also indicated R10 currently yelled out for people to bring him food or yelled "I'm hungry". The CAA further indicated other residents were not aware of R10's behavior due to his lethargic and flat personality and indicated the behaviors occurred in R10's room.

R10's Psychotropic Medication Use CAA dated

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2/7/17, indicated R10 was alert but disoriented to time and place. The CAA indicated R10 ambulated independently with the use of a wheeled walker but needed cues to destinations. The CAA further indicated R10 attempted to leave the building due to confusion level and was redirected by staff. R10 received assistance from staff with bed mobility and transfers. He had an alarm in his recliner chair to alert staff to self-transfers and for safety and was at risk for falls due to his cognition.

R10's Physician Orders dated 6/14/17, included an order for Risperdal (antipsychotic) 2 milligrams (mg) one tablet at bedtime for severe depression with psychosis. The order start date was 2/18/14. R10's Medication Administration Records for April, May and June 2017, indicated R10 received Risperdal 2 mg at bedtime daily.

R10's current Care Planning Report indicated a focus of "Behavior", dated 3/4/13, which indicated R10 had a behavior deficit related to cognitive deficits, wandering, resisting cares, and verbal outbursts/swearing. The Care Plan directed staff to provide healthy snacks/drinks at bedtime or night when he was up looking for snacks, help with adjustment to floor and routine changes, provide verbal reminders related to behavior, speak to R10 calmly and with simple terms, monitor sadness/depression and provide Florentine (antidepressant) 40 mg daily and Risperdal 3 mg at bedtime daily. The Care Plan lacked target behaviors specific to psychosis and corresponding non-pharmacological interventions to address such target behaviors.

On 6/21/17, at 2:09 p.m. R10 was observed resting in his room, in a recliner, with the foot of

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|---|---|---|---|
| | 245580 | A. BUILDING _____ B. WING _____ | 06/23/2017 |

| 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 |
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| F 428 | Continued From page 46 | F 428 | | |

the chair elevated. R10 was watching television and displayed no behaviors

On 6/21/17, at 2:32 p.m. nursing assistant (NA)-F stated R10 required extensive assistance with his activities of daily living and often got angry and swore at staff. NA-F also stated R10 did hallucinate about people in his room and had delusions that he needed to go to work. She indicated R10 may have had more issues on the evening shift. She indicated R10 sometimes wanted to go outside. NA-F stated one to one conversations, walking outside, snacks, and westerns on TV were things that would distract R10 and she indicated they would also call R10's wife if his behavior got bad. NA-F stated she reported any behaviors or mood issues to the nurse who then documented in the electronic medical record.

On 6/22/17, at 8:30 a.m. R10 was observed to ambulate independently from the dining room to his room. NA-E approached R10 in hall and asked if he could assist him to walk to his chair. Interactions between NA-E and R10 were cordial and pleasant. NA-E spoke in simple direct statements and engaged R10 in conversation. He provided verbal cues to R10 to assist him to his recliner in room. R10 was not observed to exhibit any behaviors.

R10's Pharmacy Reviews dated 7/29/16 through 5/30/17, indicated R10's medications were reviewed monthly and pharmacist recommendations/comments included but were not limited to the following:

-8/28/16: patient current psychiatric medications ok with attempted gradual dose reduction

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| F 428 | Continued From page 47 | F 428 | | |

resulting in failure as patient had adverse reactions from this. The pharmacist reviews lacked recommendations regarding target behaviors and non-pharmacological interventions for the use of Risperdal.

The facility mood and behavior monitoring for R10 was reviewed with RN-C, the DON, the VP and social worker (SW). The Questionnaire History dated 3/1/17, to 6/22/17, revealed the following:

March - behavior issues x 1 shift, specific behavior was not identified
April - no behavior issues
May - behavior issues x 2 shifts, behaviors included: repetitive verbalization, change in usual sleep pattern, repetitive physical movements.
June - behavior issues x 2 shifts, behaviors included: repetitive questions, repetitive verbalization, persistent anger with self/others x 2, complains repetitively about health, repetitive physical movements

On 6/22/17, at 1:39 p.m. RN-C confirmed R10 received Risperdal for psychosis. RN-C indicated R10 swore at staff, refused cares and could be aggressive. RN-C confirmed the behaviors identified were not individualized for psychosis. RN-C also confirmed there was no monitoring of specific target behaviors related to psychosis and non-pharmacological interventions had not been identified for R10's use of Risperdal.

On 6/22/17, at 2:20 p.m. the CP confirmed R10's record lacked target behaviors and non-pharmacological interventions for the use of Risperdal and indicated it should have been identified and addressed.

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| F 428 | Continued From page 48<br><br>The Psychoactive Medication and GDR [gradual dose reduction] policy dated 12/2016, indicated target behaviors would be identified, monitored and recorded on each shift for medications falling under the category of antipsychotic. The policy did not address ongoing use of non-pharmacological interventions with the use of antipsychotic medication. | F 428 | | |
| F 431 SS=D | 483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.<br><br>(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.<br><br>(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--<br><br>(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and<br><br>(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. | F 431 | | 8/2/17 |

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| F 431 | Continued From page 49<br>(g) Labeling of Drugs and Biologicals.<br>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.<br><br>(h) Storage of Drugs and Biologicals.<br>(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.<br><br>(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure medication labels reflected the correct physician orders for 2 of 10 residents (R1, R4) observed during a medication pass.<br><br>Findings included:<br><br>R1's physician orders dated 6/26/17, included Tylenol 500 milligrams (mg) twice per day and Tylenol 500 mg every six hours as needed (PRN).<br><br>On 6/20/17, at 7:20 p.m. during a medication | F 431 | Lakewood obtained and applied correct labels for medications in relation to residents R1 and R4. Lakewood will update its medication labeling and storage policy with specific language directing nursing staff to verify that the medication label coincides with the most recent physician order. This policy update will also include the five rights of medication administration. The policy will be updated and education will be provided to the care center nursing staff by DON by August 2, 2017. Completion will be tracked via a | |

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| F 431 | Continued From page 50<br>pass observation, licensed practical nurse (LPN)-C pulled R1's Tylenol from the drawer and compared it to the physician's order on her computer screen. The order directed to administer Tylenol 500 mg twice per day. The pharmacy label on the Tylenol bottle directed to administer 500 mg every six hours as needed. LPN-C indicated R1 also had an order for PRN Tylenol and she was not aware of why the label was incorrect and confirmed it should match the physician's order. LPN-C stated she would look into it.<br><br>On 6/22/17, at 3:20 p.m. LPN-C reported the pharmacy had been contacted and they said the Tylenol order they had on file matched the label on the Tylenol bottle. LPN-C explained the physician added the order for scheduled Tylenol twice per day on 1/16/17.<br><br>R4's physician orders dated 6/26/17, directed Duoneb inhalation solution three times daily.<br><br>On 6/22/17, at 12:38 p.m. during a medication pass, LPN-B pulled R4's nebulizer inhalation solution from a box in a drawer in the medication cart, dished up an additional oral medication and entered R4's room and administered the medications. The pharmacy label on the box of medication indicated ipratropium bromide and albuterol sulfate solutions (Duoneb) 0.5 mg/3 mg per 3 milliliter (ml) 1 nebulizer every 4 hours as needed and not three times a day as ordered.<br><br>On 6/23/17, at 1:15 p.m. vice president of patient care (VP) stated the medication labels should match the physician's orders. | F 431 | sign in sheet and compared to a staff roster with 100% compliance. Audits of medication labeling will be completed for 30% of resident population. Audits will be completed weekly for 1 month, biweekly for 3 months, then monthly for 3 months. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary. | |

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| F 431 | Continued From page 51<br>Facility policy Labeling and Storing Medicine last reviewed 12/2016 lacked guidance on procedures for ensuring pharmacy medication label corresponded with the most current physician's order. | F 431 | | |
| F 492 SS=D | 483.70(b)(c) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD<br><br>(b) Compliance with Federal, State, and Local Laws and Professional Standards.<br><br>The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.<br><br>(c) Relationship to Other HHS Regulations.<br><br>In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph.<br>This REQUIREMENT is not met as evidenced | F 492 | | 8/2/17 |

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| F 492 | Continued From page 52<br>by:<br>Based on interview, and document review, the facility failed to ensure the supplemental nursing service agency (SNSA) utilized by the facility was properly registered with the Minnesota commissioner as required. This had the potential to affect all 46 who resided in the facility.<br><br>Findings include:<br><br>On 6/20/17, at 2:00 p.m. during the entrance conference, the vice president of patient care (VP) indicated the facility utilized Nurses Pro, LLC, located in Houston, Texas as a supplemental nursing staff agency. Upon verification of the SNSA registration, it was found that the agency was not registered with the Minnesota commissioner. The VP provided a highlighted schedule identifying the pool nursing staff hired by the facility. The list included one nursing assistant (NA-C).<br><br>On 6/22/17, at 3:36 p.m. the VP confirmed NA-C was working for the facility through Nurses Pro, LLC and verified the SNSA company was not on the Minnesota registry. The VP provided a print out of the currently registered SNSA companies in the state of Minnesota and confirmed Nurses Pro, LLC was not on the registry.<br><br>The facility Supplemental Nursing Staff Policy, dated 5/15/17, indicated the status of a nursing agency's registration status with the Minnesota Department of Health Supplemental nursing Staffing Agency would occur before an interview was scheduled with a potential traveler and Human Resources would check monthly to ensure the nursing agency remained on the State registration. | F 492 | Lakewood revised our policy for SNSA on 6/26/17 to indicate that prior to a traveler interview being scheduled, human resources will verify that the travel agency is registered on the Minnesota SNSA registration. Afterwards, during the time that the traveler remains in the facility, human resources will audit monthly to ensure the agency remains on the SNSA list. If it is noted that the agency has fallen off the SNSA registration list during an audit, HR will contact the agency to request the status of their registration. This policy update will be reviewed and education will be provided by Human resources director, to the administrative team by August 2, 2017. HR will audit compliance with the policy. Audits will be completed weekly for 1 month, biweekly for 3 months, and will continue to audit monthly if any travel nursing staff are contracted by this facility. The audits will be presented to the IDT QAPI committee for 4 months or until determined they are no longer necessary. | |

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

F5580026

| 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** B. WING _____ | **06/22/2017** |

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| 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 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>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.<br><br>The building is fully sprinkler protected with a dry pipe sprinkler system installed in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a manual fire alarm system with corridor smoke detection and smoke detection in spaces open to the corridors. The system is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition). The sleeping rooms have single smoke detectors and hazardous areas have automatic fire detection installed in accordance with the Minnesota State Fire Code (2007). | K 000 | | |

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

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

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| | 245580 | A. BUILDING **01 - NURSING HOME 01** B. WING _____ | **06/22/2017** |

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| K 000 | Continued From page 1<br>The facility has a capacity of 36 beds and had a census of 31 at the time of the survey.<br><br>The requirement at 42 CFR, Subpart 483.70(a) is MET. | K 000 | | |