



Protecting, Maintaining and Improving the Health of All Minnesota

Electronically delivered
February 21, 2020

Administrator
Lakewood Health System
401 Prairie Avenue Northeast
Staples, MN 56479

RE: 245420
Cycle Start Date: January 30, 2020

Dear Administrator:

On January 30, 2020, a survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are not required.

The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action were taken prior to the survey, past non-compliance does not require a plan of correction (POC).

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition: You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty, (42 CFR 488.430 through 488.444).

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than \$10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

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**

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at <https://dab.efile.hhs.gov> no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462**

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,



Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

PRINTED: 03/10/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245420	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/30/2020
NAME OF PROVIDER OR SUPPLIER LAKWOOD HEALTH SYSTEM			STREET ADDRESS, CITY, STATE, ZIP CODE 401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS On 1/29/20 - 1/30/20, an abbreviated standard survey was completed by surveyors of this Department's staff to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. H5420043C was substantiated at F689 at past non-compliance. Although the provider had implemented corrective action prior to survey, harm or immediate jeopardy was sustained prior to the correction. The following complaints were found to be unsubstantiated: H5420040C H5420041C H5420042C Although no plan of correction is required for a finding of past non-compliance, it is required the facility acknowledge receipt of the electronic documents.	F 000			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		2/21/20	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

02/21/2020

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

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F 689	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement interventions to minimize the risk of falls for 1 of 3 residents (R4) reviewed for falls. This resulted in actual harm for R4 when she was transferred without the use of her walker and experienced a fall which resulted in a nasal fracture. Although noncompliance was present at the time of the event, the facility had implemented appropriate corrective action prior to the survey, resulting in a finding of past-noncompliance for R4.</p> <p>Findings include:</p> <p>R4's Physician Orders provided 1/30/20, indicated R4 had diagnoses which included repeated falls, long term use of anticoagulants, gait and mobility abnormalities, and history of a right femur fracture.</p> <p>R4's quarterly Minimum Data Set dated 12/10/19, indicated R4 was cognitively intact and required extensive assistance of one person for all activities of daily living (ADL) except was independent with eating. The MDS also indicated R4 was not steady with transfers or walking. The MDS further indicated R4 had experienced one fall with major injury since the previous assessment.</p> <p>R4's Falls Care Area Assessment indicated R4 was at risk for falls related to her disease process, medication use, history of falls, advanced age and immobility. R4 triggered for a significant change assessment due to now being able to ambulate, and with improvement in</p>	F 689	Past noncompliance: no plan of correction required.		

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F 689	<p>Continued From page 2</p> <p>transfers and eating. R4 has a diagnosis of atrial fibrillation and on long term use of an anticoagulant, hypertension, pain, and arthritis. She is able to verbalize and use the call light, but staff were to anticipate her needs. R4 required staff assistance for all her ADLs.</p> <p>R4's undated Care Plan indicated R4 had physical challenges, a history of falling, and required staff assistance with all mobility. The Care Plan also indicated R4 had a history of right femur fracture prior to admission and was diagnosed with a nasal fracture in November, 2019, both of which were related to a fall. The Care Plan further indicated R4 was unsteady with transfers and demonstrated an inability to safely transfer independently. The Care Plan directed staff to keep an eye on behaviors, request a therapy screen if needed, remind to ask for help, make sure important items are within reach, use the following assistive devices: FWW (front wheeled walker) or wheelchair, to observe for unmet needs (such as pain, toileting, hunger and thirst), use non-skid footwear, encourage to use assistance, report signs of pain to nurse, assist with transfers or when walking, attempt to anticipate needs, and attempt to keep bedside table within reach when in recliner. The Care Plan also indicated R4 required assistance of one person with a FWW for transfers from all surfaces in room and used a PAL (a sit to stand lift) to get into bed at night.</p> <p>On 1/30/20, at 9:44 a.m. R4 was observed in her room, seated in recliner in her room with the foot of the recliner elevated. A bedside table was next to the recliner and the call light was within reach. R4 rested with eyes closed</p>	F 689			

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F 689	<p>Continued From page 3</p> <p>-At 10:21 a.m. remained quietly seated in the recliner, fully reclined. No attempts to self transfer observed.</p> <p>-At 10:37 a.m. R4 was seated fully upright in the recliner. Nurse entered room to administer medications.</p> <p>On 1/30/20, at 1:23 p.m. R4 was observed in the therapy department doing exercises with physical therapy assistant (PTA)-A.</p> <p>-At 1:25 p.m. PTA-A prompted R4 to stand and R4 started on her own before PTA-A assisted. PTA-A cued R4 to wait for assistance. R4 stood up between the parallel bars and worked on standing exercises with PTA-A</p> <p>-At 1:48 p.m. R4 finished exercises and wheeled over to the bike area. R4 transferred with assist of one and the use of a FWW and gait belt. PTA-A cued R4 to keep the walker close and turn and step back, reach for the chair, and sit on the seat of the bike. PTA-A assisted R4 to position feet on the pedals and hands on grips. R4 began to pedal on the bike.</p> <p>-At 2:02 p.m. R4 completed the bike exercise and transferred with assist of one and the FWW back to the wheelchair. PTA-A wheeled R4 from the therapy room to her own room, and assisted to transfer to recliner with use of gait belt and FWW. R4 transferred well but required cues to keep walker close to her body. PTA-A removed the gait belt and cued R4 to sit back in the chair, raised foot of recliner, placed call light on R4's lap, a pillow under R4's feet and a blanket on her lap.</p> <p>Review of R4's Progress Notes from 11/1/19 to 12/3/19, revealed R4 experienced a fall on 11/8/19, at 8:20 p.m. in her room. The note</p>	F 689			

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F 689	<p>Continued From page 4</p> <p>indicated staff was assisting R4 from the recliner to the wheelchair when the fall occurred. R4 sustained a laceration to the nose and a nasal fracture.</p> <p>A Nursing Home Incident Report (NHIR) submitted to the State Agency (SA) dated 11/11/19, indicated on 11/8/19, nursing assistant (NA)-A was transferring R4 to her recliner after R4 requested to go to the bathroom and go to bed. NA-A had a transfer belt on R4, and was standing next to her. The chair was at an angle. R4 was wearing gripper socks. When R4 started to pivot, she lost her balance and fell down to the ground. NA-A also went down to the ground with R4. R4 hit her head on the floor, neuros's were started and she was sent to the ER. R4 had a laceration to her nose and received five sutures. R4 also received a closed fracture of the nasal bone. In further review of event, it was discovered that a FWW had not been used during the pivot transfer. Care plan was updated to use a PAL lift until further evaluation. Will review footwear. Staff education provided to all staff related to falls and pivot transfers.</p> <p>The 5-Day Investigation submitted to the SA dated 11/12/19, included an investigation summary which indicated after further investigation it was discovered that NA-A did not go to the ground with R4. NA-A stated that the transfer belt had loosened up after R4 stood up and that was when R4 started to lose her balance. NA-A tried to stop R4 from falling but was not able to do. It was verified with at least three staff that R4 did have a transfer belt on when she fell. Family did mention R4's</p>	F 689			

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F 689	<p>Continued From page 5</p> <p>preference was for staff to use the PAL lift instead of a pivot transfer at bedtime because it helped her get further back on the bed. This was not in R4's care plan at the time of the fall. Family also stated R4 should wear shoes with transfers and not gripper socks. This was also not in R4's Care plan at the time of the fall. The investigation concluded R4's care plan was not followed as R4 had been transferred with one assist and gait belt and the care plan directed assistance with one to pivot and the FWW.</p> <p>On 1/30/20, at 2:07 p.m. PTA-A stated R4 did not have good safety awareness. PTA-A indicated R4 was improving on transitions from sitting to standing but needed cuing and assistance with her walker as she tended to push it out too far in front of her and could not get it into position with verbal cues. PTA-A stated she had to move the walker for her. PTA-A further stated based on today's session, R4 would not be safe to transfer without a walker.</p> <p>On 1/30/20, at 3:29 p.m. R4 verified she had had a fall and broke her nose. R4 stated the NA who was helping her did not use her walker and she fell. R4 stated the NA's at night used a PAL lift to transfer her and that went well, however, the NA's in the daytime did not use the PAL. R4 verified she was supposed to use a walker with transfers and indicated sometimes they [the NA's] used it and sometimes they did not. R4 stated she tries to tell them, but they [staff] do not listen to her.</p> <p>On 1/30/20, at 3:46 p.m. NA-B stated R4 usually used a FWW and assistance with transfers and ambulation in the daytime and then on the</p>	F 689			

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F 689	<p>Continued From page 6</p> <p>evenings used a PAL lift. NA-B stated R4 was more tired in the evening and needed the extra assistance. He stated they would use the walker versus the PAL depending on how R4 was doing that day. NA-B verified R4 needed to use the walker for transfers and was not to be transferred without it.</p> <p>On 1/30/20, at 4:01 p.m. registered nurse (RN)-A verified R4 had a fall on 11/8/19, at 8:20 p.m. when she fell/lost balance during an assisted transfer from recliner to the wheelchair. RN-A indicated it had been determined upon investigation that R4's walker was not used at the time of the fall. RN-A also indicated they had found a discrepancy in communication between nursing and physical therapy (PT) related to when PT directed a pivot transfer, it meant to use a device to stabilize the resident such as a walker, but to nursing, a pivot transfer just meant to stand and pivot with no device needed. RN-A stated therapy had been working with R4 at the time of the fall. RN-B referenced R4's care plan on the computer and indicated, at the time of the fall, the care plan directed R4 required transfer with assist of one and the FWW which had been initiated 10/7/19. RN-A verified R4 was not safe to transfer without the walker per therapy and indicated R4 had one leg longer than the other subsequent to hip surgery. RN-A indicated they were working on getting R4 a built up shoe with the hopes that she would have increased function. RN-A and RN-B confirmed if staff had used the walker as directed, it was possible R4 may not fallen and broken her nose.</p> <p>On 1/30/20, at 4:23 p.m. the director of nursing (DON) verified NA-A had not followed R4's care</p>	F 689			

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F 689	<p>Continued From page 7</p> <p>plan and received education regarding this after the fall. DON confirmed NA-A should have transferred R4 with the assistance of a FWW as directed on her care plan.</p> <p>The Fall/Injury Risk policy dated 6/20/18, indicated all patients would be assessed upon admission (and re-assessed every quarter, after a fall or with a significant change) using the Fall Assessment & Re-evaluation Tool. An individual plan of care related to safety and fall prevention would be completed. Family would be consulted for individualizing fall prevention interventions, if available. Appropriate interventions would be initiated. The patient and family would be educated about the safety interventions in place.</p> <p>The past non-compliance that began on 11/8/19, was verified during the 1/28-1/29/20, onsite visit and reviewed to be corrected by 11/12/19. Verification of corrective action was confirmed by interviews with a variety of nursing staff, observations, and document review. Training and education was completed for all staff. On-going monitoring of resident cares implemented in order to prevent future incidents.</p> <p>The action plan implemented included:</p> <ul style="list-style-type: none"> -review of resident care plans -PT/T involvement which identified the discrepancy related to the definition of a pivot transfer. Educated all staff in the definition of a pivot transfer -included R4's family with the development of interventions -incorporated the use of standing lifts into facility skills fair. 	F 689			

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F 689	Continued From page 8 -referred R4 to Speech therapy in an attempt to improve speech/communication related to disease process. -reviewed and/or revised policies and procedures. Reviewed with staff and educated the staff on changes made. -implemented plan for staff on all shifts to review care plans to ensure accuracy related changes in resident ability as it related to the time of day. -Educated all staff on implementation of the care plan. -implemented a monitoring system to ensure compliance.	F 689		

Minnesota Department of Health

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2 000	<p>Initial Comments</p> <p>*****ATTENTION*****</p> <p>NH LICENSING CORRECTION ORDER</p> <p>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.</p> <p>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.</p> <p>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.</p> <p>INITIAL COMMENTS: On 1/29/20, and 1/30/20, an abbreviated survey was conducted to determine compliance of state licensure. Your facility was found to be in compliance with the MN state licensure.</p> <p>The following complaint was found to be substantiated with no licensing orders issued:</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 02/21/20
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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00667	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/30/2020
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NAME OF PROVIDER OR SUPPLIER LAKWOOD HEALTH SYSTEM	STREET ADDRESS, CITY, STATE, ZIP CODE 401 PRAIRIE AVENUE NORTHEAST STAPLES, MN 56479
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	<p>Continued From page 1</p> <p>H5420043C</p> <p>The following complaint were found not to be unsubstantiated:</p> <p>H5420040C H5420041C H5420042C</p> <p>The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.</p>	2 000		