STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Methodist Health Care Center	610 Summit Drive Fairmont, MN 56031

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation and interviews the facility failed to ensure grievance forms were posted in prominent locations throughout the facility for residents and resident representatives to file grievances, and anonymously. This had the potential to affect all 66 residents in the facility. Findings include:On 11/18/25 at 10:30 a.m., during the resident council meeting, residents R7, R25, R26, R42, R43, and R62 stated they were not aware of any method to submit concerns anonymously. The residents also reported that grievance forms were not readily available and could only be obtained by asking staff. R25 further stated grievance forms had previously been available in multiple locations throughout the facility but were no longer accessible to residents without requesting them from staff.On 11/18/25 at 12:12 p.m., during a facility tour, social services (SS)-A confirmed there were no grievance forms in the designated areas accessible to all residents, which were expected at the end of each wing on first and second floor. SS-A stated grievance forms had previously been available at the end of each of the facility's two wings on both floors but was unsure when the forms were removed. SS-A stated grievance forms were also available around the corner from the front entrance and acknowledged that this location was not accessible to all residents. SS-A stated residents could submit completed grievance forms to SS-A or to any staff member and confirmed there was no designated location for anonymous submission of grievance forms.On 11/19/25 at 10:09 a.m., the administrator stated the facility was expected to have grievance forms available for the residents at the end of each wing and was unaware the grievance forms were no longer at the end of each wing as expected. The facility Filing Grievances Policy undated, indicated: Any resident, his or her resident representative, family member, or appointed advocate may file a grievance concerning treatment, medical care, behavior of other residents, staff members, missing items without fear threat or reprisal in any form.Upon admission residents are provided with written information on how to file a grievance a copy of grievance procedures is posted in the area located near the main entrance.

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.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure a care plan was implemented to ensure activity preferences were identified and implemented for 1 of 2 residents (R31) reviewed for activities.R1's admission Minimum Data Set (MDS) dated [DATE], indicated R1 was admitted to the facility 10/16/25, had moderately impaired cognition, required partial to moderate assistance with transfers, and substantial/maximal assistance with shower/bathe and dressing, and required supervision with eating and oral hygiene. R1 identified it was somewhat important to do her favorite activities, keep up with the news, participate in religious services, go outside to get fresh air, have reading material, listen to music, and do things with groups of people. R1's diagnoses included anemia, heart failure pneumonia, macular degeneration (chronic eye condition that affects retina leading to significant visual impairment) and depression. R1's baseline/comprehensive care plan dated 11/3/25, did not include R4's activities, interests or interventions related to activities. R1's Comprehensive Care Area Assessment (CAA) dated 10/29/25, did not include activities. An Activity assessment dated [DATE], included R1 was content to be in her room, resting in a recliner and watching television. R1 had supportive daughters who visit when they can. R1 does enjoy music. Will continue to invite to small groups. On 11/17/25 at 3:52 p.m., R1 was observed in her room seated in a recliner asleep. The television was off and no radio or music device was visualized in the room. At 3:59 p.m., family member (FM)-A entered R4's room. FM-A stated they had just gotten back from an eye doctor appointment for R1's vision issues. FM-A stated the facility had been aware of R1's vision issues but did not think they were doing anything to address it. FM-A turned the TV on and stated the screen was not even full on the TV and R1's recliner was too far away for her to see it. FM-A stated she doesn't believe R1 goes to any activities and it would be good for her to get out of her room. FM-A was not sure if staff had been inviting her to activities as she visits about once a week. R1 slept throughout interview with FM-A. On observation 11/18/25 at 11:06 a.m., R1 was in her recliner asleep. Lights and TV were off. On interview 11/18/25 at 11:10 a.m., NA-D stated R1 has family that visits weekly but tended to stay in her room. NA-D stated R1 asked to go back to her room after meals and tended to sleep most of the time. NA-D doesn't believe R1 went to any activities and was unsure if activities is inviting her. On observation and interview 11/18/25 at 12:39 p.m., R1 was in her recliner dozing. FM-B was present and stated she doesn't think R1 attended any activities at least when she has been at the facility and is unsure if she was being asked to participate. FM-B was not aware of music this afternoon and stated she will take R1 there as she enjoyed music. FM-B did not think anyone had offered R1 a radio or CD player for her to listen to music. On observation 11/18/25 at 1:12 p.m., FM-A and FM-B wheeled R1 out of her room and was observed walking throughout the facility. At 1:30 p.m., FM-A and FM-B took R1 to the music event. R1 returned to her room at 2:30 p.m. On interview 11/18/25 at 3:03 p.m., LPN-A stated R1 tends to stay in her room and sleep. LPN-A indicated she has noted the TV on in R1's room on occasion. LPN-A was not sure but assumed activities staff are inviting her to all activities. On interview 11/19/25 at 9:50 a.m., nursing assistant (NA)-C stated R1 had not been at the facility long but hasn't seen R1 go to any activities. NA-C stated R1 tended to stay in her room and sleep. Review of activity participation documentation for R1 included 10/28/25: attended activity briefly this afternoon, 10/29/25: attended Bingo with family member briefly, 10/31/25: refused to attend trick or treat and 11/18/25: attended special music. No other refusals were documented. On interview 11/19/25 at 10:42 a.m., social services (SS)-A confirmed R1's plan of care did not include an activities plan. SS-A stated R1 had been sleepy since she had been at the facility, which may impact her attending activities. On interview 11/19/25 at 10:57 a.m., activities director (AD)-A stated she was responsible for assessing activity needs on admission and quarterly and developed the plan of care from that information. AD-A reviewed R1's (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record and confirmed there was not a plan of care for activities stating I must have missed that one.AD-A stated they invite R1 to activities but she frequently declines. On interview 11/19/25 at 11:55 a.m., the director of nursing (DON) stated all residents should have a care plan for activities. The DON added the facility does have resources for visually impaired residents and that should be part of the plan of care for activities. A facility Activity Programs/Care Plan policy was requested but not received.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure individualized activities were care planned and provided for 1 of 2 residents (R1) reviewed for activities. Findings include: R1's admission Minimum Data Set (MDS) assessment dated [DATE], indicated R1 was admitted to the facility 10/16/25, had moderately impaired cognition, required partial to moderate assistance with transfers, and substantial/maximal assistance with shower/bathe and dressing, and required supervision with eating and oral hygiene. R1 identified it was somewhat important to do her favorite activities, keep up with the news, participate in religious services, go outside to get fresh air, have reading material, listen to music, and do things with groups of people. R1's diagnoses included anemia, heart failure pneumonia, macular degeneration (chronic eye condition that affects retina leading to significant visual impairment) and depression. R1's baseline/comprehensive care plan dated 11/3/25, did not include R4's activities, interests or interventions related to activities. R1's Care Area Assessment (CAA) dated 10/29/25, included visual impairment related to macular degeneration. R1 was at risk for complications and will monitor for changes in vision, offer examinations as needed and tell resident where to place items and keep room in order per resident preference. The CAA did not include activities. An Activity assessment dated [DATE], included R1 was content to be in her room, resting in a recliner and watching television. R1 had supportive daughters who visit when they can. R1 does enjoy music. Will continue to invite to small groups. On 11/17/25 at 3:52 p.m., R1 was observed in her room seated in a recliner asleep. The television was off and no radio or music device was visualized in the room. At 3:59 p.m., family member (FM)-A entered R4's room. FM-A stated they had just gotten back from an eye doctor appointment for R1's vision issues. FM-A stated the facility had been aware of R1's vision issues but did not think they were doing anything to address it. FM-A turned the TV on and stated the screen was not even full on the TV and R1's recliner was too far away for her to see it. FM-A stated she doesn't believe R1 goes to any activities, and it would be good for her to get out of her room. FM-A was not sure if staff had been inviting her to activities as she visits about once a week. R1 slept throughout interview with FM-A. On observation 11/18/25 at 9:31 a.m., staff assisted R1 with dressing and then assisted R1 via wheelchair to the dining room. At 9:50 a.m., R1 was assisted back to her room and asked to lay down. R1 transferred to her bed with assist of one staff . Lights were turned off. On observation 11/18/25 at 11:06 a.m., R1 was in her recliner asleep. Lights and TV were off. On interview 11/18/25 at 11:10 a.m., NA-D stated R1 has family that visits weekly but tended to stay in her room. NA-D stated R1 asked to go back to her room after meals and tended to sleep most of the time. NA-D doesn't believe R1 went to any activities and was unsure if activities is inviting her. On observation and interview 11/18/25 at 12:39 p.m., R1 was in her recliner dozing. FM-B was present and stated she doesn't think R1 attended any activities at least when she has been at the facility and is unsure if she was being asked to participate. FM-B was not aware of music this afternoon and stated she will take R1 there as she enjoyed music. FM-B did not think anyone had offered R1 a radio or CD player for her to listen to music. On observation 11/18/25 at 1:12 p.m., FM-A and FM-B wheeled R1 out of her room and was observed walking throughout the facility. At 1:30 p.m., FM-A and FM-B took R1 to the music event. R1 returned to her room at 2:30 p.m. On interview 11/18/25 at 3:03 p.m., LPN-A stated R1 tends to stay in her room and sleep. LPN-A was not sure but assumed activities staff were inviting her. On interview 11/19/25 at 9:50 a.m., nursing assistant (NA)-C stated R1 had not been at the facility long but hasn't seen R1 go to any activities. NA-C stated R1 tended to stay in her room and sleep. Review of activity participation documentation for R1 included 10/28/25: attended activity briefly this afternoon, 10/29/25: attended Bingo with family member briefly, 10/31/25: refused to attend trick or treat and 11/18/25: attended special music. No other refusals were documented. On interview 11/19/25 at 10:42 a.m., social services (SS)-A confirmed R1's plan of care did not include an (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	activities plan. SS-A stated R1 had been sleepy since she had been at the facility, which may impact her attending activities. On interview 11/19/25 at 10:57 a.m., activities director (AD)-A stated she was responsible for assessing activity needs on admission and quarterly and developed the plan of care from that information. AD-A reviewed R1's medical record and confirmed there was not a plan of care for activities stating I must have missed that one. AD-A stated staff document in the medical record activity attendance and refusals. AD-A stated she had met with R1 and FM-B when R1 was admitted and offered talking books which they declined and the family was going to look into getting her a CD player. AD-A stated they invite R1 to activities but she frequently declines. On interview 11/19/25 at 11:55 a.m., the director of nursing (DON) stated all residents should have a care plan for activities. The DON added the facility does have resources for visually impaired residents and that should be part of the plan of care for activities. The DON stated when activities were attended, it should be documented in the medical record along with when they refuse. A facility Activity Programs/Care Plan policy was requested but not received.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide routine passive range of motion (PROM) on a consistent basis to improve strength, mobility and improve circulation for 1 of 1 resident (R32) reviewed for ROM. In addition, the facility failed to identify and develop interventions to reduce the risk of potential complications of a hand contracture.Findings include:R32's facesheet printed on 11/19/25, included diagnoses of traumatic brain injury, Parkinson's disease, and dementia.R32's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated severe cognitive impairment, no speech, rarely/never understood, sometimes responded to simple, direct communication only. Dependent upon staff for all activities of living (ADL). R32's physician orders dated 4/13/21, indicated restorative nursing measures such as PROM, ambulation, transfers, ADL may be implemented following an assessment by a licensed nurse.R32's care plan, undated and printed on 11/19/25, indicated R32 had an alteration in musculoskeletal status related to impaired mobility and cognition. R32 would be free of complications related to immobility. Daily hand hygiene. Monitor/document/report contracture formation. PROM to be completed with am/pm (morning and evening) cares as tolerated. In addition, the care plan indicated R32 had Parkinson's affecting movement. Staff were to report a decline in ROM. The care plan did not identify right hand contracture nor interventions to reduce the risk of potential complications, such as use of a hand splint, palm protection, or focused PROM to hand. R32's TASK tab in the electronic medical record (EMR) indicated: Range of Motion Exercises: Passive Range of Motion to joints per CNA education, not a specific OT program to be done by CNA, every shift. Review of documentation for this task for the past 30 days from 10/21/25, through 11/19/25, indicated NAs were to document the number of minutes spent providing PROM. Findings indicated R32 received PROM only 30% of the time in that time frame, specifically:Number of opportunities to perform PROM was 90 (every shift x 30 days).Actual number of times PROM was documented as being performed was 27 times.Number of refusals were 10.Number of times NAs documented not applicable was 29 times (16 times on the day shift, four times on the evening shift and nine times on the night shift).During a telephone interview on 11/17/25 at 2:00 p.m., family member (FM)-C stated R32 did not receive PROM exercises to his extremities. During an interview on 11/17/25 at 2:45 p.m., licensed practical nurse (LPN)-B stated she thought R32 was on a restorative program and exercises would be posted inside his closet door. During an observation at 2:49 p.m., there were no exercises posted inside the closet in R32's room.During an observation and interview on 11/18/25 at 9:30 a.m., observed nursing assistants (NA)-F and NA-G in room with R32, wheeling R32 out of the bathroom after having a shower. While in bed getting dressed, observed fingers on right hand were clenched; fingers on left hand loosely open and knees were flexed. Both NA-F and NA-G stated R32 could not straighten his legs anymore. NA-G stated, you can pull them down, but then he bends them up again. At 9:47 a.m., when R32 was dressed and in the Broda chair (a specialized positioning wheelchair), NA-G stated R32 was not able to open the fingers of his right hand and as she was talking, she pulled the fingers open. The palm of R32's hand was still moist from the shower. Fingernails were moderately long with some dark material under some nails. NA-G cleaned nails on both hands with a wooden manicure stick and trimmed the nails. NA-G stated staff did not usually put anything in R32's right palm to protect his skin, adding sometimes a washcloth but it did not stay in place. No PROM exercises were observed as being done during this episode of care.During an interview on 11/19/25, at 9:14 a.m., occupational therapist (OT)-B stated she had not seen R32 for occupational therapy, so could not comment on his right-hand contracture or if OT had recommended a restorative program for him. OT-B stated current records only go back three years and, in that time, R32 had not been evaluated by OT.During an interview on 11/19/25 at 9:22 a.m., registered nurse (RN)-C who was also the resident care coordinator for the unit (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on which R32 resided stated she was aware of R32's right hand contracture. Looking in the EMR at R32's care plan, RN-C acknowledged there was nothing in his care plan specific to the contracture and stated there should have been. RN-C stated documentation of PROM to R32's joints would be found in the TASK tab in the EMR and stated PROM exercises were typically posted in a resident's closet. RN-C stated PROM exercises should be done every shift. Looking in the EMR, RN-C stated it did not look like PROM had been done every shift - more like once or twice a day, but not every day. RN-C stated R32 was not able to speak so would not be able to verbalize a refusal of PROM. RN-C could not recall if R32 came to the facility in 2017 with a right-hand contracture or if it developed over time after he was admitted . RN-C stated she would expect something to protect R32's right palm and would talk to OT about an appropriate device, adding, We need to make sure to protect his palm. Together with RN-C, went to R32's room and verified no PROM exercises were posted inside his closet or elsewhere in the room.During an interview on 11/19/25 at 9:37 a.m., RN-C presented what she referred to as standard ROM exercises that NAs learned in NA class. The pages numbered 51 and 52 of an unidentified book were titled Skill #48 PROM (Hip, Knee, Ankle) with a 10-step procedure and Skill #49 PROM (Shoulder, Elbow) with a 7-step procedure. The PROM was not specific to R32. When asked, RN-C stated she would have expected PROM exercises to be specific to R32, his needs and his ability. These documents did not include PROM exercises for R32's right hand contracture. Further, RN-C stated she had talked to NA's who told her R32's way to refuse PROM was by clenching up. RN-C stated she would expect NA staff to inform a nurse if R32 refused PROM and in turn, she be notified. RN-C stated she was not aware of refusals as no one had told her that. During record review, no documentation of PROM refusals was noted in progress notes. RN-C was not aware R32 had not had a physical or occupational evaluation for at least three years.During an interview on 11/19/25 at 10:01 a.m., NA-B stated she did PROM for R32; that his exercises where inside his closet (they were not) and NAs did it as often as they could. NA-B stated they did abduction and adduction of his shoulders, elbows, hips and knees. NA-B stated R32 often tensed up when doing PROM and that was how they knew he wanted to stop. NA-B was asked if R32 needed PROM for his hands and replied, No, his hands are good - just his joints. During an interview on 11/19/25 at 11:34 a.m., the director of nursing (DON) was informed of findings and stated RN-C was already addressing it. The DON was informed of the observation on 11/18/25, during morning cares when PROM was not done; the lack of identification and intervention for R32's right hand contracture or for palmar protection. The DON was informed that R32 had not had an OT evaluation for at least three years according to OT-B. R32's refusals of PROM exercise had not been communicated from NAs to nursing staff for follow up. The DON stated she had known R32 since his admission in 2017, and stated he had overall become stiffer and, We should have caught that, and gotten OT involved. Need to get better and look at this.Facility Restorative Nursing Care policy dated 4/30/14, indicated residents would be given appropriate treatment and services to maintain or improve his/her abilities, as indicated by residents' comprehensive assessment, to achieve and maintain the highest practicable outcome. General restorative nursing care is that which does not require the use of a qualified professional therapist to render care. Facility Range of Motion (Active, Active Assistance and Passive) policy dated 7/17/22, indicated the purpose was to move the residents' joints through as full a range of motion as possible, to improve or maintain joint mobility and muscle strength, to prevent contractures, to increase strength and activity tolerance, to reduce pain, to prevent complications of mobility. The policy included body parts, such as neck, shoulder, elbow, etc. with specific instructions for each. Inform nurse of any changes in residents' ability and/or complaints of discomfort or pain. When the resident's activity level or joint function is at risk of/or decreases, range of motion should be slated as soon as possible. Joints begin to stiffen within 24 hours of disuse.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure basic infection control practices were followed when the tubing of a urinary drainage bag for 1 of 1 resident (R8), was observed laying on the floor of the shower. The deficient practice had the potential to cause infection.Findings include:R8's face sheet printed on 11/19/25, included diagnoses of stroke, obstructive and reflux uropathy (blockage that prevents urine from flowing, causing it to back up), bacteremia (bacteria in blood) and history of urinary tract infections.R8's annual Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, usually understood and could understand. R8 had a urinary catheter. R8 walked with supervision or touch assistance or used a wheelchair for mobility.R8's physician orders dated 2/10/25, included indwelling catheter. R8's undated care plan, printed on 11/19/25, indicated R8 had an indwelling catheter related to retention. Catheter care per facility policy. During an observation on 11/17/25 at 3:19 p.m., observed R8 wearing a urinary leg bag on her right lower leg. In R8's bathroom, observed an overnight urinary drainage bag hanging from a handicap bar in the shower. The distal end of the urinary drainage bag tubing laid on the floor of the shower with no protective cap over the insertion tip. During an interview and observation on 11/17/25 at 3:21 p.m., together with nursing assistant (NA)-A, looked at the location of the tubing. NA-A stated, Oh, that should not be there. NA-A stated the overnight bag was supposed be placed into the small clear waste bag tied to the bar next to drainage bag. NA-A collected the urinary drainage bag and discarded it, stating he would get a new one. NA-A stated the catheter bag tubing should not touch a dirty surface because it could cause an infection. During an observation on 11/18/25 at 9:57 a.m., observed R8's overnight urinary drainage bag inside a small clear waste bag tied to a handicap bar in the shower. During an observation on 11/19/25 at 8:00 a.m., observed R8's overnight urinary drainage bag hanging from a bar in the shower. The distal end of the urinary drainage bag tubing laid on the floor of the shower with no protective cap over the insertion tip. During an observation and interview on 11/19/25 at 8:26 a.m., together with registered nurse (RN)-A who was also the interim infection preventionist, observed the location of the urinary drainage bag and tubing. RN-A stated the set up was not supposed to be left like that; it should have been placed in the small clear waste bag tied to the bar. RN-A stated the floor of the shower was not clean and R8 could potentially develop a UTI if the dirty tip was attached to her urinary catheter. RN-A stated staff were trained on proper management of urinary drainage bags.During an interview on 11/19/25 at 9:12 a.m., RN-B, who was also the MDS nurse looked in R8's electronic medical record (EMR) and stated R8's last UTI's were in February 2025. During an interview on 11/19/25 at 9:29 a.m., RN-C who was also the resident care coordinator for the unit on which R8 resided stated she had been informed of the observation of the urinary drainage bag. RN-C stated NAs would have had training on proper handling of the urinary drainage bag during NA training, including the facility-specific process of tying a waste bag to the shower bar and placing the entire urinary drainage bag and tubing inside when not in use. During an interview on 11/19/25 at 10:01 a.m., NA-B stated she had disconnected R8's overnight urinary drainage bag that morning, flushed it with bleach water, then put it in the waste bag in the shower. When informed the urinary drainage bag had not been in the waste bag, she stated it may have popped out. When informed the entire urinary drainage bag and tubing had been hanging next to the waste bag, NA-B admitted it was possible she had forgotten to put the urinary drainage bag into the waste bag. NA-B stated the tubing laying on the floor of the shower created a potential risk for infection for R8. During an interview on 11/19/25, at 11:40 a.m., the director of nursing stated she had been informed of findings by staff, and stated NAs would be re-educated on proper handling of urinary drainage bags when not in use. Policy on handling urinary drainage bags was requested and not received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Methodist Health Care Center	610 Summit Drive Fairmont, MN 56031

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure documentation for 2 of 5 residents (R65 and R5) who refused influenza vaccine included education covering benefit and risk of the vaccine, and name and date of resident or representative who refused the vaccine Findings include:R65's face sheet printed on 11/19/25, indicated R65 was admitted on [DATE], and diagnosis included Parkinson's disease.R65's admission Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, was understood and could understand. R65 used a walker or wheelchair for mobility. R65's standing orders dated 6/11/25, indicated may have annual Influenza vaccine unless contraindicated. During record review for immunizations, the immunization section of the electronic medical record (EMR) indicated the influenza vaccine had been refused, however no additional documentation indicated when it had been offered, if education had been provided including benefit and risk, if allergic or contraindicated. During an interview on 11/19/2025 at 8:00 a.m., registered nurse (RN)-B who was also the MDS nurse, provided documentation of refusal for R65's pneumococcal vaccine, but stated there was no documentation for refusal of the influenza vaccine. RN-B stated the infection preventionist, who oversaw the vaccine program, was on leave of absence and therefore she did not know why the documentation was missing. R5's face sheet printed on 11/19/25, indicated R5 was admitted on [DATE], and diagnosis included dementia. R5's admission MDS assessment dated [DATE], indicated moderately impaired cognition, clear speech, could understand and be understood. R5 did not walk and used a wheelchair for mobility. R5's standing orders dated 6/10/25, indicated may have annual Influenza vaccine unless contraindicated. During record review for immunizations, the immunization section of the EMR indicated the influenza vaccine had been refused, however no additional documentation indicated when it had been offered, if education had been provided including benefit and risk, if allergic or contraindicated. During interview on 11/19/2025 at 8:00 a.m., registered nurse (RN)-B who was also the MDS nurse, stated she could not locate documentation of refusal for the influenza vaccine. RN-B stated the infection preventionist, who oversaw the vaccine program, was on leave of absence and therefore she did not know why the documentation was missing. During an interview on 11/19/25, at 11:40 a.m., the director of nursing stated she had been informed of findings by staff.Facility Influenza Vaccination policy, undated, indicated all residents would be offered the influenza vaccine annually. Residents and family may refuse the vaccine; this would be documented under the immunization tab in the electronic medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245280	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakeview Methodist Health Care Center	610 Summit Drive Fairmont, MN 56031

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure documentation for 1 of 5 residents (R65) who refused Covid-19 vaccine included education covering benefits and risks of the vaccine, and name and date of resident or representative who refused the vaccine. Findings include:R65's face sheet printed on 11/19/25, indicated R65 was admitted on [DATE], and diagnosis included Parkinson's disease.R65's admission Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, was understood and could understand, used a walker or wheelchair for mobility. R65's physician orders did not include Covid-19 immunization. During record review for immunizations, the immunization section of the electronic medical record (EMR) indicated the Covid-19 vaccine had been refused, however no additional documentation included when it had been offered, if education had been provided including benefit and risk, if allergic or contraindicated. During interview on 11/19/2025 at 8:00 a.m., registered nurse (RN)-B who was also the MDS nurse, provided documentation of refusal for R65's pneumococcal vaccine, but stated there was no documentation for refusal of the Covid-19 vaccine. RN-B stated the infection preventionist, who oversaw the vaccine program, was on leave of absence and therefore she did not know why the documentation was missing. During an interview on 11/19/25, at 11:40 a.m., the director of nursing (DON) stated she had been informed of findings by staff.In an email dated 11/20/25 at 10:57 a.m., the DON indicated the Covid-19 immunization was not on the facility standing orders as were other immunizations and was in the process of adding it. Facility Covid-19 Vaccine policy dated 9/1/25, indicated the residents medical record must include documentation that indicated, at a minimum, the resident or resident representative was provided education regarding the benefits and potential side effects of the Covid-19 vaccine, and that the resident (or representative) either accepted and received the Covid-19 vaccine or did not receive the vaccine due to medical contraindications, prior vaccine, or refusal. If there was a contraindication to the resident having the vaccination, the appropriate documentation must be made in the medical record.