STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245420	A. Building B. Wing	02/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lakewood Health System	401 Prairie Avenue Northeast Staples, MN 56479

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure nebulizer medications were administered safely for 1 of 1 resident (R44) who were observed to self-administer a nebulizer and had not been assessed as safe to self-administer medications. R44's quarterly Minimum Data Set (MDS) dated [DATE], indicated R44 had no cognitive impairment and had a diagnosis which included hemiplegia (one-sided weakness), and hypertension (high blood pressure). Furthermore, R5 required maximum assistance with bed mobility, transfers, toileting, and personal hygiene.R44's care plan revised 5/29/25, identified R44 had chronic obstructive pulmonary disease (COPD). Care plan interventions were to elevate head of bed to 30 degrees or propped on pillows or out of bed upright in a chair during episodes of difficulty breathing. Care plan lacked information regarding self-administration of medications.Review of R44's electronic health record (EHR) lacked a self-administered medication (SAM) assessment.R44's Order Review History Report signed 2/16/26, directed staff to administer Ipratropium-Albuterol inhalation solution 0.5-2.5 3 milligrams (mg)/3 milliliters (ml), inhale via nebulizer three times a day related to other specified chronic obstructive pulmonary disease (COPD) and 3 ml inhale orally via nebulizer every 24 hours as needed for wheezing, shortness of breath, rinse mask and allow to air dry after each use.R44's Order Review History Report lacked an order to self-administer medication.R44's electronic medical administration record (EMAR) for February 2026, lacked directions to self-administration medications. During an observation on 2/17/26 at 5:17 p.m., R44 was sitting in room in a wheelchair with a nebulizer mask on his face and no steam coming out of the mask with no staff present. At 5:18 p.m., R44 turned on the call light and stated he had to use the bathroom, with no staff present in the room, nebulizer mask on his face and no steam coming out of the mask. At 5:19 p.m., trained medication aid (TMA)-A went into the room, and R44 told TMA-A that his nebulizer was done and he had to use the bathroom. TMA-A took off the nebulizer mask and sat it on the dresser and informed R44 she would rinse the mask out later and was going to find a nursing assistant to help him to the bathroom.During an interview on 2/17/26 at 5:45 p.m., TMA-A verified she had placed the nebulizer mask on R44, turned on the machine, and left the room. TMA-A identified her normal process was to put the medication in the nebulizer, place the mask on R44, and set a timer for ten minutes. TMA-A indicated she does not sit with R44 during his nebulizer treatments. TMA-A stated if a resident was able to self-administer a medication, it would be identified in the EMAR. TMA-A pulled up R44 EMAR and was unable to find information regarding self-administration of medications.During an interview on 2/18/26 11:31 a.m., registered nurse (RN)-A indicated for a resident to self-administer medications, a registered nurse would do an assessment and then reach out to the provider for an order. RN-A verified R44 did not have a self-administration of medication order. RN-A indicated it was important to do the self-administration of medication assessment to ensure a resident does not pull off the nebulizer mask, and ensure the resident get the medication in the nebulizer treatment. If a resident does not have a self-administration assessment done, she would have expected staff to sit with the resident during the nebulizer treatment.During an interview on 2/18/26 at 2:24 p.m., director of nursing (DON) indicated a resident needed to have a self-administration assessment completed to self-administer medication. After a resident was (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	assessed and was deemed safe to self-administer medications, staff would identify in the care plan the resident was safe to self-administer medications and would obtain orders from the provider. DON verified R44 did not have a SAM assessment completed. DON stated this is important to ensure the resident received the medication as ordered. A facility policy titled Self-Administration of Medications reviewed 6/13/25, identified if the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive, physical, and visual abilities to carry out this responsibility, during the care planning process. The licensed nurse will determine resident's ability to self-administer medications by a means of a skill assessment, which is conducted on a quarterly basis. The results of the licensed nurse's assessment are recorded on the medication self-administration assessment, which is placed in the resident's medical record. If a resident has orders for nebulizers the nurse may assess that the resident is able to deliver the nebulizer after set up and then will go back after nebulizer has run and shut off the machine and take care of the equipment.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to provide routine shaving for 1 of 1 residents (R39) who was dependent on staff for assistance with personal hygiene.Findings Include: R39's quarterly Minimum Data Set (MDS) dated [DATE], identified R39 had moderate cognitive impairment and diagnoses which included; paraplegia (paralysis of lower body), Alzheimer's disease and multiple sclerosis (chronic neurological disorder that affects the nerve cell coverings and may cause numbness, weakness, vision changes and fatigue). R39's MDS identified R39 required substantial/maximal assistance with personal hygiene. R39's Functional Abilities Care Area Assessment (CAA) dated 6/27/25, identified R39 required substantial/maximal assistance with personal hygiene. R39's CAA identified R39 was able to verbalize, but staff also had to anticipate his needs. R39 needed and received staff assistance with all activities of daily living (ADL) tasks. R39's comprehensive care plan revised 12/10/25, identified R39 had an ADL self-care performance deficit related to impaired balance related to multiple sclerosis. R39's care plan interventions included touching assistance from wheelchair level for oral care and shaving. R39's medical record lacked documentation of R39 refusal of shaving. During an observation on 2/17/26 at 2:14 p.m., R39 had approximately one quarter inch long white facial hair across his lower face and neck area. At 4:53 p.m., R39 stated he would like to be shaven daily, but was unable to determine the last time he was shaved. During a phone interview on 2/17/26 at 5:31 p.m., family member (FM)-A stated R39 would like to be shaved every day but was not sure if the staff had the time to shave R39. During an observation on 2/18/26 at 9:15 a.m., R39 was seated in his wheelchair in the activity room doing exercises with other residents and staff. R39 continued to have white facial hair present across his lower face and neck. At 10:56 a.m., R39 was in wheelchair in sitting area with other residents, while they were watching television. R39 continued to have facial hair. R39 informed surveyor he needed to be shaved. During an interview on 2/18/26 at 11:06 a.m., nursing assistant (NA)-A indicated she had completed morning cares with R39, and R39 had whiskers today. NA-A stated the bath aides usually shaved R39 on Mondays. NA-A indicated she had offered to shave R39 at times, but did not offer to shave R39 today. NA-A stated her usual practice was to offer shaving to residents if facial hair was present and if refused to let the nurse know. During an interview on 2/18/26 at 1:37 p.m., licensed practical nurse (LPN)-A confirmed R39 had whiskers today, and stated she had shaved R39 about twenty minutes ago, because he needed to be shaved. LPN-A stated the nursing assistants were responsible to shave residents. LPN-A stated they did have a few residents the nurses were to document on the treatment administration records (TAR) that they were specifically shaved. LPN-A indicated she was unaware R39 wanted to be shaved daily, but would discuss with unit manager to possibly add R39 to the TAR to assure they offered R39 to be shaved daily. During an interview on 2/18/26 at 1:41 p.m., director of nursing (DON) indicated her expectation was to offer shaving daily, unless otherwise care planned. DON stated it was important to offer to shave residents to make them feel neat and clean, and possibly for infection prevention. On 2/18/26 at 3:48 p.m., DON e-mailed indicating the facility did not have a policy for shaving residents, but nursing staff were taught to offer shaving daily per resident preference.