

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on observation, interview and document review the facility failed to ensure a call light or device to alert staff was accessible for 1 of 1 residents (R21) observed to not have a way to call for staff assistance while sitting in their room.</p> <p>Findings include:</p> <p>R21's quarterly Minimum Data Set (MDS) dated [DATE], identified R21 was cognitively intact and required moderate to maximum assistance to transfer and had sustained a fall since his admission to the facility.</p> <p>R21's care plan dated 8/13/24, identified R21 was dependent on staff for meeting emotional, intellectual, physical and social needs related to physical limitations and cognitive deficits. R21 was also at risk for falls and had an actual fall without injury. The care plan outlined several interventions to maintain involvement and help reduce his risk of falls, which included to ensure that adaptive equipment was provided, present, and functional.</p> <p>On 9/9/24 at 12:42 p.m., R21 was observed sitting in a recliner in his room in a reclined position. No call light was observed near or in the recliner. A call light and reacher assistive device was observed lying across a round table in the corner of the room. The table was three to four feet away from R21's recliner and R21 was not able to reach any of the items on the table from where he was sitting. R21 stated he had a call light by his bed but did not have one within his reach when sitting in his recliner. He did not know what he would do if he needed to get staff assistance to the bathroom or if he needed something. R21 stated staff forgot to place the call light with in his reach quite often.</p> <p>On 9/10/24 at 4:36 p.m., nursing assistant (NA)-D was observed wheeling R21 to his room and transferred him to his recliner. NA-D turned on R21's television and provided him a snack on his bedside table next to the recliner. R21's call light and reacher device were observed to be on R21's round table three to four feet from the recliner. NA-D left the room without providing R21 with his call light or reacher device.</p> <p>During interview on 9/10/24 at 4:45 p.m., NA-A stated R21 was capable and did use his call light to call for staff assistance. All residents should have their call lights with in their reach when in their rooms. She would go in right away and give R21 his call light.</p> <p>(continued on next page)</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	

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)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>When interviewed on 9/11/24 at 8:35 a.m., registered nurse (RN)-B stated R21 was able to use his call light and should have it with in his reach at all times. She would obtain a splitter for his call light cords so he could have one attached to his recliner to ensure he had one accessible at all times.</p> <p>During interview on 9/11/24 at 10:25 a.m., the director of nursing (DON) stated it was the expectation that all residents have their call lights within their reach. The facility taught the staff to do deliberate rounding and at that time they were to check with the residents to see they have everything they needed, such as the call light and water.</p> <p>The facility policy Call Light Response dated 4/1/14, identified it was the facility policy to provide prompt responses to the requests and needs of the elders. When providing care to residents staff were to be sure to position the call light conveniently for the resident to use. The staff were to tell the resident where the call light was and how to use it. The staff were to be sure all call lights were placed within resident reach at all times and never on the floor or bedside stand.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	
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)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>40943</p> <p>Based on observation, interview, and document review the facility failed to maintain confidentiality for 12 of 12 residents (R3, R4, R6, R8, R11, R14, R17, R19, R22, R24, R76, R77) whose personal health data was observed laying unattended in a public area visible to all who entered.</p> <p>Findings include:</p> <p>Team 1 (South) Memory Lane care sheet undated, identified personal care needs for all 12 residents residing on that wing. The information included: urinary intake/output, fasting blood sugars, bed/chair alarms, size and type of incontinent products, glasses, hearing aids, safety concerns, behaviors, and ability to perform Activities of Daily Living (ADL's).</p> <p>During an observation and interview on 9/10/24, at 8:46 a.m., nursing assistant (NA)-B was in the dining room requesting a meal for a R19. NA-B stated she had a care sheet that provided the care needs of all the residents on her assigned wing, but NA-B had left it on the table over there pointing towards the hall. The care sheet was observed uncovered and left unattended on a tabletop in the public hallway. Staff, visitors, and residents were observed walking to and from the dining room for the breakfast meal, past the table and had the ability to view the information without obstruction. NA-B stated the care sheet was left on the table because she had been working at the facility for a while, and knew the residents' care needs so she would just mark residents off as she completed their cares. NA-B stated this was her normal routine. NA-B stated another resident, visitor or other staff could look at the care sheet and NA-B would not know unless she was at the table at the time. NA-B would not answer why it was important to keep resident personal information private.</p> <p>During an interview on 9/10/24 at 9:12 a.m., NA-C stated the care sheets should always be folded and in your pocket. If kept on the table, it should be in a place so it can be covered and where no one can see it. The care sheet should never be left out where others can see it because that's private information. If left on the table, anyone could pick it up and look at it.</p> <p>During an interview on 9/10/24 at 9:18 a.m., trained medication aide (TMA)-A stated the care sheet should never be left in a place where others can look at it because it was private resident information.</p> <p>During an interview on 9/10/24 at 9:32 a.m., TMA-B stated the nursing assistants were supposed to keep the care sheets on them so they can refer to them during cares. The care sheet should never be left at a table because other residents and/or family could pick it up and let that personal information out.</p> <p>During an interview on 9/10/24 at 11:02 a.m., registered nurse (RN)-C stated the nursing assistants should keep the care sheet in their pockets to refer to it during cares and to keep the resident information private.</p> <p>During an interview on 9/10/24 at 12:57 p.m., the director of nursing (DON) stated staff were expected to keep resident information private.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	
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)		
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/10/24 at 2:06 p.m., the administrator stated staff were expected to keep resident information private.</p> <p>A facility policy regarding privacy was requested but not received.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	

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)
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40943</p> <p>Based on observation, interview, and document review, the facility failed to ensure fall interventions were implemented as care planned to prevent falls for 1 of 4 residents (R19) reviewed for falls. This resulted in actual harm to R19 who's fall resulted in a humerus (a long bone in the arm that runs from the shoulder to the elbow) fracture.</p> <p>Findings include:</p> <p>R19's Therapy Eval and Re-Eval note dated 12/13/23 at 11:30 a.m., identified R19 was a high fall risk. R19 had difficulty following directions and was able to ambulate with contact guard assist (CGA) (a term used in physical therapy and occupational therapy to describe a level of assistance provided to a resident. Contact guard requires a hand on the resident (such as with a gait belt), hover hands, light hands, contact with the resident) and use of front-wheeled walker (FWW), but R19 chose to use a wheelchair for most mobility at that time.</p> <p>R19's Fall Risk assessment dated [DATE], identified R19 was at high risk for falls.</p> <p>R19's significant change Minimum Data Set (MDS) dated [DATE], identified R19 had severe cognitive impairment and diagnoses including Alzheimer's disease, dementia, and anxiety. R19 had impairment to one side of her upper body and required substantial/maximal assistance for Activities of Daily Living (ADL's).</p> <p>R19's Falls Care Area Assessment (CAA) dated 8/15/24, identified R19 was a fall risk due to a history of falls and dementia, and was unable to make safe/sound decisions. This area would be addressed in the care plan to slow or minimize decline, avoid complications, minimize risks, and to maintain current level of function.</p> <p>R19's care plan revised 8/16/24, identified R19 had an ADL self-care performance deficit related to Alzheimer's disease and dementia. R19 required a contact guard assist (CGA) with 2 staff and a gait belt to stand/pivot transfer. R19 was unsafe to walk, stand pivot transfers only with 2 person and a gait belt. However, the care plan lacked to identify if R19 could be left unattended at the bedside.</p> <p>The Team 1 (South) Memory Lane care sheet undated, identified R19 required extensive to total assist of 1-2 staff; floor bed, bed alarm with no chime and chair alarms; transfer with assist of 2, gait belt, stand and pivot; 1 hour safety rounding; turn slowly when in bed due to vertigo; gripper socks while in bed; brace on 24/7, skin checks twice a day, do not get wet, bed bath. The care sheet lacked to identify if R19 could be left unattended at the bedside.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	
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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>R19's Incident note dated 8/12/24 at 12:02 p.m., identified R19 had a fall that morning at 7:35 a.m. R19 was in her bathroom standing at the sink. NA went to grab R19's wheelchair just outside the bathroom door when the NA turned around R19 had fallen to the floor. R19 was on her right side, floor was dry, R19's shoes were on, the room had bright lighting, the room was quiet. R19 had just been toileted prior to the fall. R19 was lifted with a mechanical lift with 3 staff assisting. R19 was evaluated by nursing. R19 had a small skin tear to right side of forehead that was bleeding. When doing range of motion, R19 was unable to move right shoulder area. R19 was sent to emergency room (ER) for further evaluation.</p> <p>R9's Incident note dated 8/12/24 at 12:25 p.m., identified R19 returned from the ER around 10:30 a.m. R19 was to keep her right arm always immobilized with the use of a sling due to a fracture of the right humerus.</p> <p>R19'a CR/Shoulder 1V Rt dated 8/12/24, identified a non-displaced fracture of the right humerus.</p> <p>R19's Fall Risk assessment dated [DATE], identified R19 was at high risk for falls.</p> <p>R19's High Risk Meeting note dated 8/13/24 at 12:57 p.m., identified R19's fall was discussed. R19's sling was to be left on continuously. Medications had been implemented for pain management. Physical (PT) and occupational (OT) therapy evaluation for transfers and recommendations was requested. Weekly weights to ensure no weight loss. Assist with meals as needed. R19 would have appointment with orthopedics.</p> <p>R19's Therapy Eval and Re-Eval note dated 8/14/24 at 1:45 p.m., identified R19 fell on [DATE] and sustained a right humerus fracture and an OT evaluation was ordered to determine best way to provide care for R19. R19 was in an immobilizer sling and pain was being managed with narcotic and muscle relaxer medications. R19 had an appointment scheduled with orthopedics on 8/15/24. OT rearranged the room which included moving the bed to the other side of the room, allowing staff access on either side of the bed and for R19 to enter/exit the bed leading with the left side. Gripper strips placed alongside the bed and in front of the toilet. R19 would need extensive to total assistance with ADL's at that time. Care needed to be taken with putting on the gait belt to keep it low and not bump her right arm. Move slowly, provide clear and simple instructions. Stand pivot transfers with 2-person assistance; no ambulation; use wheelchair for functional mobility. R29 was fearful of falling and needed extra time and reassurance from staff. Care needed to be taken to keep right upper extremity relaxed (R19 tended to tighten this arm up which increases pain). New arrangement of room should help make access easier for staff and R19.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	
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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's 5-day report dated 8/16/24 at 2:49 p.m., identified staff did not follow the plan of care. The equipment needed to care for R19 was not accessible to NA-B when it was needed and NA-B did not retrieve the equipment prior to assisting R19. The corrective action plan was initiated including R19 evaluation by physician, PT/OT, Orthopedics; immobilize right arm with sling, change dressing routinely. Education to all staff regarding assistive devices, the need for all equipment to be available to the resident when needed. Care plan was updated for R19 and her dressing and transferring needs. An audit of all resident walkers to ensure that they were available and had their name on it. Interviewed cognitively intact residents that use gait belt for audit of gait belt use by staff. Creating a walk to dine policy. R19's weight will be monitored as well and her intakes to ensure R19 continues to eat and maintain her weight, weekly. However, the corrective action plan lacked to identify staff failure to provide contact guard assist for R19 nor education and/or audits that R19 was receiving contact guard assist to ensure her safety.</p> <p>During an observation on 9/10/24 at 8:13 a.m., the following was observed as nursing assistant (NA)-B provided morning cares to R19:</p> <ul style="list-style-type: none"> - At 8:29 a.m., NA-B stated to R19, alright, we're going to sit up. I need to get you in your wheelchair and wash your back a little bit. NA-B lowered R19's bed to wheelchair height, however, left R19's wheelchair was at the foot of R19's bed. NA-B grasped R19 in a cradle lift and turned/lifted R19 to sit on the left side of R19's bed. NA-B stated to R19 can you hold the rail and hold yourself up? I'm going to take my arm away. R19 was observed to grasp the bed siderail with her left hand tightly causing the knuckles of her left hand to blanch. - At 8:32 a.m., NA-B removed R19's shirt. NA-B turned her back on R19 while rinsing a washcloth in the basin of water. R19 balanced on the edge of R19's bed while holding on to the siderail. NA-B turned back to R19 and washed R19's underarms and back. - At 8:33 a.m., R19 stated she wanted to go to her own room. NA-B explained it was R19's room and took 3 steps away from R19 to obtain deodorant from R19's drawer. NA-B assisted R19 with her deodorant and putting on a sweater. - At 8:36 a.m., NA-B stated we're going to hop in your wheelchair and go get breakfast. Sound like a plan? Hold the rail and I'm going to get the gait belt so I can get you in your wheelchair. NA-B took 5 steps away from R19 to the end of R19's bed, obtained the gait belt from R19's wheelchair and then placed R19 wheelchair next to R19. - At 8:37 a.m., NA-B placed a gait belt on R19 and stated we're going to stand and pivot into the chair, ok? NA-B stood R19 and pivoted R19 to her wheelchair. There you go. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	
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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/10/24 at 8:46 a.m., NA-B stated R19 had fallen in her bathroom. R19 basically face-planted, fell and broke the top part of her right arm. Staff couldn't leave her alone in the bathroom. If staff needed something you had to ask for it. Staff could not turn your back or walk away from her. NA-B stated staff did not have a way to ask for assistance other than turning the call light on. R19 was an assist of 1-2 depending on her day. Like today, R19's was doing really well and NA-B felt comfortable doing a pivot transfer. NA-B stated she did turn her back on R19 to rinse the washcloth and did step away from R19 to get deodorant, the gait belt, and to put the wheelchair in place for R19's transfer. NA-B then stated she did not carry a care sheet in her pocket because she had worked at the facility for a while, knew the residents' care needed and just marked residents off as she completed tasks. Upon review of R19's care plan, NA-B stated she did transfer R19 with assist of 1 but did not know how to answer what R19's care plan directed.</p> <p>During an interview on 9/10/24 at 9:12 a.m., NA-C stated she was working the morning of 8/12/24 when R19 fell . R19 was at the bathroom sink and the nursing assistant that was with her stepped outside the bathroom to get the wheelchair. R19 fell and broke her arm. Staff were directed to do an assist of 2 stand and pivot for all transfers for R19. Staff assisted R19 with everything. Staff cannot step away from R19. No. Nope. Never. Staff needed to look at the care sheets to make sure they know what care needs every resident required. That's what the care sheet was for. The care sheet should be always folded and in their pockets.</p> <p>During an interview on 9/10/24 at 9:18 a.m., trained medication aide (TMA)-A stated they talk about what resident needs/changes were in report before every shift, but staff needed to check the care sheet to make sure. R19 could not be left out of reach at all and R19 needed an assist of 2 for all transfers as R19 was a high risk for falls.</p> <p>During an interview on 9/10/24 at 9:32 a.m., TMA-B stated she was working the other hallway the morning R19 fell . TMA-B didn't know a whole lot but knew R19's walker and gait belt had been left in the dining room the night before and weren't in her room. Normally, R19 walked to and from meals so the walker was left in the dining room from the night before. TMA-A stated she did not know if R19 was wearing a gait belt when she fell . TMA-B was never in the room and TMA-B was never informed if R19 was or wasn't wearing one. Prior to her fall, R19 could be very agile when she wanted to be. TMA-B stated she did not know if R19 ever had vertigo but R19 could be unsteady. Staff had to use a gait belt and have contact at all times to make sure R19 didn't fall. After R19's fall, staff were told to use the care plans, know what residents' needs were and to make sure all the devices to keep residents safe were available for use. Staff should never step away from R19. Right now, she's a stand and pivot with assist of 2 and a gait belt. Really, staff should only walk away from R19 if she's lying down with the bed to the floor with mats on each side or if she's with other staff.</p> <p>During an interview on 9/10/24 at 10:39 a.m., NA-A stated R19 used to be a fun, spunky lady before her fall. If R19 needed to use the bathroom, she could tell you. R19 was able to walk with a walker and a gait belt. R19 had vertigo and when R19 would get up she'd say she was dizzy. Staff had to stay by her, keep your hand on her, and tell her to take her time. Staff should never step away from R19. Now, R19 was completely different and was terrified to fall again. R19 should always be an assist of 2 for that reason.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	
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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/10/24 at 10:49 a.m., NA-E stated she was assisting R19 the morning R19 fell . NA-E was getting R19 up to the bathroom and to get ready for the day. NA-E had assisted R19 to sit on the edge of the bed and NA-E was looking for R19's walker and gait belt. When NA-E had realized the walker and gait belt were not in R19's room, R19 had already started walking to the bathroom. R19 was known to just get up and walk. NA-E walked with R19 to the toilet and assisted R19 to sit down and changed R19's incontinent brief. NA-E did not turn on R19's call light to request someone find R19's walker and gait belt. NA-E assisted R19 to stand and walk to the sink to do oral cares. R19's wheelchair was outside R19's door. NA-E took maybe 3 steps away from R19 with NA-E's back was turned away from R19, as I'm doing that, R19 lost her balance and fell on to the floor. NA-E stated, because NA-E was turned to the wheelchair, NA-E did not see R19 fall. R19 had been really steady. She wasn't stumbling or losing her balance. R19 should have had a gait belt on her and a walker to walk and had never stood at the sink without a gait belt or walker before that day. Afterwards, NA-E had a meeting with registered nurse (RN)-C and the director of nursing (DON). NA-E was instructed to [NAME] ensure R19 had the gait belt and walker before R19 started moving. NA-E stated she told RN-C and the DON, R19 was already moving and NA-E couldn't leave her. However, R19 had not been moving prior to NA-E sitting her up at the edge of the bed nor did NA-E request assistance once R19 was seated on the toilet. After R29 fell , NA-E pushed the call light. However, R19 was bleeding from the cut above her eye and NA-E had to leave the room to the nurses's station to get assistance. R19 was now an assist of 2 for a stand pivot to get up out of bed. When I go into a room and start to help a resident, I need to make sure I have all the things I need before I start to make sure the resident is safe. NA-E stated R19 could not be left alone in the bathroom, however, did not know if R19 could sit on the edge of her bed without staff contact.</p> <p>During an interview on 9/10/24 at 11:02 a.m., RN-C stated R19 had lived at the facility approximately a year or so. R19 had fallen at a previous facility and was pretty calm the first few months of living at the facility. R19 became more active, but fluctuated. Previously, R19 could be sitting in the dining room with her walker and ambulate with a 1 person stand-by assist. Sometimes, R19 needed to self-propel in her wheelchair. Prior to R19's fall, R19 required extensive assist of 1 stand by assist. After R19's fall, interventions included bed and chair alarm, proper footwear, low bed with mats on the floor, not safe to walk, stand and pivot only with assist of 2 and a gait belt. RN-C stated it was hard to say if R19 could be left to sit on the edge of her bed and staff could turn away or walk away from R19 because RN-C would use her judgement in the moment to know if R19 appeared unsteady. You have to turn and grab a towel. Things like that. RN-C stated she had not assessed R19 to determine if she was safe to sit on the edge of her bed without staff contact. Most of the time, nursing requested PT and OT to assess that for residents. RN-C stated staff were always expected to follow R19's care plan.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	
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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 9/10/24 at 12:57 p.m., the DON stated, prior to R19's fall, R19 required a contact guard assist of 1 person. R19 walked to and from the dining room for meals. Contact guard assist meant R19 could walk to dine with a walker, gait belt and staff made sure they had contact with the gait belt at all times. R19 would require the railing and staff assist of 1 for transfer but was able to do that fine. R19 was a little unsteady and would go way too fast, and take off down the hallway without you. R19 just didn't know how to [NAME] that in to be at a safe pace and was impulsive. Regarding R19's fall, most importantly, we need to follow the care plan and it was care planned to use a gait belt. The walker should have been present as well and was part of the care plan. Staff were educated on the importance of using the care planned devices to keep residents safe. When R19 was standing at the sink, NA-E was to have a hand on the gait belt at all times to ensure R19 was safe. NA-B should have had a hand on R19 at all times and should have performed a stand pivot transfer with assist of 2 to ensure R19 was safe.</p> <p>During an interview on 9/10/24 at 1:18 p.m., the DON stated staff were provided education regarding regulatory expectations, the care plans and the care sheets, and assistive devices and gait belts were included. Staff signed off on attendance. The facility performed audits to ensure all assistive devices were accounted for and labeled with the resident's name. However, audits were not performed to ensure walkers were returned to the resident's room after meals, or to ensure staff were following the care plans. Additionally, a R19 did receive a PT/OT evaluation on how to transfer R19 safely but did not address safety such as the requirement of a contact guard assist.</p> <p>During an interview on 9/10/24 at 1:34 p.m., the occupational therapist (OT)-A stated R19 was evaluated by OT and PT in August after R19's fall because R19 was fearful of falling. That's what R19 needed at that time, reassurance. The OT stated R19 was not evaluated for contact guard assist while seated at the edge of the bed, but contact guard assist should continue to be used until evaluated.</p> <p>R19's OT Evaluation LCC 24-5580 dated 9/11/24 at 10:23 a.m., identified NA completed lower body dressing while R19 was still supine in bed. NA then assisted R19 to side of bed. R19 held her body stiff with posterior lean while she sat on the edge of the bed. OT stayed beside her and explained task of putting gait belt on while NA completed task. This helped keep R19 calm and then OT did stand pivot from bed to wheelchair with moderate assistance. R19 still demonstrated a posterior lean and needed cueing and time to move her feet with pivoting. Once seated in the wheelchair, NA was able to complete grooming tasks with R19. NA and OT were able to position R19 in wheelchair for better comfort. Assessment: R19 needed time and simple explanation of tasks while staff were working with her. R19 did express fear with movement so staff needed to be attentive and reassuring during functional mobility. R19 needed 2-person assistance for safety with stand pivot transfers. Tasks such as grooming could be completed with 1 staff if R19 was sitting in the wheelchair. All other tasks that involved moving from a supine to sitting to standing position should be completed with 2 staff.</p> <p>During an interview on 9/10/24 at 2:06 p.m., administrator stated staff were expected to follow the care plan to ensure resident safety.</p> <p>The facility policy Falls Prevention revised 8/7/24, identified it was the intent of the facility to ensure the provision and environment that was free from hazards over which the organization had control and provides the appropriate supervision to each resident to prevent avoidable accidents. This includes systems and processes designed to:</p> <ul style="list-style-type: none"> - Identify hazards and risks. <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	
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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<ul style="list-style-type: none"> - Evaluate and analyze hazards and risks. - Implement interventions to reduce hazards and risks. - Monitor for effectiveness and modify approaches as indicated. - Residents receive supervision and assistive devices to prevent avoidable accidents. <p>Implementation of Falls Management:</p> <ol style="list-style-type: none"> 1. Each fall will be followed by the High-Risk Committee per the committee guidelines on a weekly basis until interventions are deemed appropriate. See High Risk Committee guidelines for more info. 2. Identification of residents in the facility that the committee evaluates to focus on fall reduction includes: those who have experienced injury from a fall within the last 3 months, those who have had one or more falls in the last 30 days, those who have a physical restraint, those who are newly admitted to the facility, are at risk for future falls due to the aging process, disease process, physiological factors or medications, those who are at risk for incidents related to environment, elopement issues or behavioral issues. 3. A fall risk assessment is used to assess all residents at the time of admission, readmission, identification of a significant change in status, and then on a quarterly basis thereafter to continuously assess for fall potential. 4. An inventory of interventions or approaches is used for preventing falls. The interventions are documented, and effectiveness is evaluated, care plans updated, and communicated to staff responsible for implementation. 5. Staff is provided with in-service training on a regular basis to include training on new safety devices or equipment recommended and implemented. Staff is trained to recognize and eliminate environmental hazards and how to provide adequate supervision to prevent falls. 6. The effectiveness of selected interventions is evaluated by IDT team during the High-Risk Committee meeting to analyze patterns of falls within the facility. This is done through an incident reporting system (IRIS). 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40948</p> <p>Based on observation, interview, and document review, the facility failed to ensure unpasteurized shelled eggs were fully cooked and prepared in a manner to prevent foodborne illness. This had the potential affect 5 of 5 residents (R4, R10, R13, R20, and R21) who regularly ordered undercooked eggs for breakfast, with the potential to affect all 24 residents.</p> <p>Finding include:</p> <p>R4's quarterly Minimum Data Set (MDS) dated [DATE], identified no cognitive impairment and had a diagnosis of diabetes.</p> <p>R10's quarterly MDS dated [DATE], identified no cognitive impairment and had a diagnosis of Parkinson's disease.</p> <p>R13's quarterly MDS dated [DATE], identified severe cognitive impairment.</p> <p>R20's quarterly MDS dated [DATE], identified no cognitive impairment and had a diagnosis of cancer of prostate.</p> <p>R21's quarterly MDS dated [DATE], identified no cognitive impairment and had a diagnosis of chronic kidney disease and autoimmune thyroiditis.</p> <p>During observations and interview on the initial kitchen tour on 9/9/24 at 12:15 p.m., the cook's refrigerator had 7 flats of eggs (one flat contained 30 eggs). The flats, as well as the box which the flats came in, did not indicate the eggs were pasteurized. [NAME] (C-A) looked at the eggs and the box they came in and stated there was no indication they were pasteurized. C-A would assume the eggs were pasteurized, because residents would order eggs over-easy (prepared undercooked with runny yolks), and the eggs should be pasteurized if being served that way.</p> <p>During observation on 9/10/24 at 7:27 a.m., C-A started to make breakfast for R13 which included 2 over-easy eggs from the eggs in the cook's refrigerator. The same eggs from the day before. The eggs were removed from the griddle at 7:29 a.m. and plated with bacon and toast. At 7:35 a.m. the dietary aide picked up the plate for R13 and started to walk to the dining room to give the plate to R13. The surveyor stopped the dietary aide from delivering the over-easy eggs and checked with C-A who stated it was not verified if the eggs were pasteurized. C-A remade R13 eggs and were cooked until firm.</p> <p>During observation on 9/10/24 at 7:46 a.m., R4 had come to the kitchen door and requested 2 over-easy eggs. R4 received scrambled eggs instead.</p> <p>During observation in the dining room R10 was heard saying she was going to order over-easy eggs because she likes to dip the toast in it. R10 did not receive over-easy eggs.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During and interview on 9/10/24 @ 8:15 a.m., the social worker (SW) stated they assisted with the ordering and had been ordering the same eggs for the past 6 months. SW was unsure if the eggs which had been ordered were pasteurized or not. The SW opened the food distributors web site and identified the type of eggs that had been ordered and stated they did not say if they were pasteurized. The description of the eggs identified To prevent illness from bacteria cook eggs until yolks are firm. They had not ordered the eggs that were identified as pasteurized and this could make the residents ill.</p> <p>During an interview on 9/10/24 at 2:36 p.m., R21 stated they like breakfast in the morning and will usually get eggs over-easy. R21 had not had any gastrointestinal (GI) issues when he ate eggs.</p> <p>During an interview on 9/10/24 @ 2:41 p.m., R20 stated they like their eggs prepared either over-easy or over-medium. Likes the yolks to be runny. R20 had not complained of any GI issues from eating eggs.</p> <p>During an interview on 9/10/24 at 2:45 p.m., R4 stated they like to order eggs over-easy with sausage. R4 had not complained of any GI issues from eating eggs.</p> <p>During a phone interview on 9/10/24 at 2:26 p.m., the dietician stated it is the expectation the facility would use pasteurized eggs when breakfast was prepared for the residents. Using unpasteurized eggs for under cooked or runny eggs could cause serious infection, illness and could lead to death.</p> <p>During an interview on 9/10/24 at 2:49 p.m., the administrator stated the expectation was to ensure food was prepared safely for the residents and would expect pasteurized eggs be used to ensure resident safety.</p> <p>The United States Department of Agriculture (USDA)-Food Safety and Inspection Service article Shell Eggs from Farm to Table dated 11/4/19, identified it is possible for shell eggs to be infected with salmonella enteritis (a bacterial disease that can cause GI illness in humans and can have severe consequences in highly vulnerable people, like the young, old, and immunocompromised). To prevent illness from bacteria, cook eggs until the yolks are firm.</p> <p>A policy regarding ordering food and food safety was requested, but none were received.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	
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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Implement a program that monitors antibiotic use.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41575</p> <p>Based on interview and document review, the facility failed to implement antibiotic stewardship protocols for 1 of 1 resident (R7) identified to have been taking an antibiotic.</p> <p>Findings include:</p> <p>R7's quarterly Minimum Data Set (MDS) dated [DATE], identified severe cognitive impairment. Diagnoses included dementia, urinary tract infections, unspecified psychosis, and encounter for palliative care.</p> <p>R7's care plan revised 4/9/24, identified R7 was incontinent of bowel and bladder and was totally dependent with eating and toileting. Staff were directed to provide assistance with meals and snacks and check and change for incontinence every two hours.</p> <p>R7's progress notes identified the following:</p> <ul style="list-style-type: none"> -On 6/26/24, urinalysis (UA) sample was obtained via straight catheterization and delivered to the lab. -On 6/27/24, discussed with family regarding underlying potential urinary tract infections (UTI) due to continual incontinence, requesting maintenance dose of an antibiotic for prophylactic use. Education was given regarding antibiotic stewardship and use of antibiotics was discussed and family still preferred nursing to contact provider and request a low dose of antibiotic. Chart audit indicated UTI treatments two to three times over the past couple of years. Obtaining a current UA for baseline resulted in a positive UTI and order of a course of treatment followed by an maintenance dose for UTI prevention. Probiotics were also incorporated. Family was updated. -On 7/2/24, antibiotic time out. Culture was received and showed resistance to ciprofloxacin. The provider was contacted and an order to discontinue ciprofloxacin and give Rocephin 1 gram intramuscularly (IM). One time only was received. -On 7/9/24, the family requested a repeat UA or other intervention due to R7 having had a UTI on 6/26/24. Family reported R7 was still not eating quite right. Primary physician was notified and an order was received for Rocephin 1 gram IM for five days for symptoms of UTI. <p>R7's progress notes were reviewed 6/11/24 through 7/11/24. The medical record lacked evidence of any assessment of signs and/or symptoms of infection. Further, there was no evidence of obtaining a UA and/or culture prior to initiating antibiotic treatment on 7/9/24.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	
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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During interview on 9/10/24 at 1:21 p.m., registered nurse (RN)-A stated R7 had a positive UA on 6/26/24, and so ciprofloxacin had been initiated, then the culture came back the following week and indicated resistive to ciprofloxacin. The physician then ordered one dose of Rocephin. The real problem was that it took so long to get the culture back, which was an ongoing problem for the facility. She had discussed with the pharmacist possible solutions and they had thought to try to hold the antibiotic until culture results were received and push water, cranberry juice, and other interventions until they received culture results. Starting residents on antibiotics before reviewing the culture results could result in not properly treating and they were inviting a risk for Clostridium difficile colitis (a germ (bacterium) that causes diarrhea and colitis (an inflammation of the colon) and can be life-threatening). RN-A felt there should have been an assessment and/or non-pharmacological intervention for symptoms and education to the family prior to calling the physician for a second course of antibiotic treatment. The facility was working on trying to get some kind of protocols or assessment in place for staff to use when signs or symptoms of infection were suspected.</p> <p>When interviewed on 9/11/24 at 9:40 a.m., RN-B stated the family felt R7's decreased appetite was a symptom of still having a UTI and they wanted us to do more, so they had contacted the physician and he ordered the Rocephin for five days. She did not know why a patient assessment or interventions such as increased fluids had not been implemented first. The facility's normal procedure was to start a three day UTI tracking form and push fluids. Then they reviewed that and determined if a urinalysis was needed. After reviewing the progress notes for R7, RN-B stated she would have done a three day UTI tracking form or at least spoken with staff to see if they were seeing any symptoms or issues with R7 prior to contacting the physician for a second course of antibiotic treatment. The facility was working on improving their documentation regarding signs and symptoms of infection and the use of antibiotics.</p> <p>During interview on 9/11/24 at 10:09 a.m., the director of nursing (DON) stated they had just been discussing the infection control program and things they could do for documenting in the medical record, such as what staff were seeing for symptoms of infection. There was a lag in their system that the facility did not get their cultures back in a timely manner. That was a big handicap for the facility. The expectation was that the staff would need to assess the signs and symptoms and determine what nurse was assessing. They do use a UTI tracking form and then the nurses do an evaluation of those findings. Looking for things such as fever, lethargy, a decrease in urine output, or foul urine. It would have been more appropriate for staff to have put R7 on a UTI tracking form and monitor for symptoms of infection prior to contacting the physician for antibiotic treatment.</p> <p>Facility Infection Control policy dated 6/24, identified the facility's antibiotic stewardship program aimed to optimize the treatment of infections and reduce adverse events associated with antibiotic use. Objectives included to promote a culture of optimal antibiotic use and ensure timely and appropriate initiation of antibiotics. Actions and interventions included the development of antimicrobial related policies, appropriate use guidelines, microbiology lab susceptibility reporting and evidence based care paths and order sets for infectious diseases and active targeted interventions to guide, monitor and encourage appropriate use.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245580	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER Lakewood Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 Main Avenue South Baudette, MN 56623	
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)		
<p>F 0881</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's Urinary Tract Infection policy revised date 12/17, identified procedures for staff to use which included to identify residents with probable urinary tract infections. Signs and symptoms would include urinary frequency, pain on urination, confusion, loss of appetite, back pain, low grade temperature, vomiting, nausea, decline in functional status, increased pain, anxiety and possible elevated blood sugar. Staff were to initiate a UTI tracking form for three days to identify the presence of three symptoms of UTI. Along with monitoring, staff were to push fluids and supplement or offer cranberry juice to decrease symptoms related to decreased fluid intake. If there were not three symptoms identified, the registered nurse would evaluate and follow up with provider if needed. If three symptoms were identified the provider could be contacted immediately.</p>		