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

# MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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

ID: 2V6G
Facility ID: 00682

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245388**

2. STATE VENDOR OR MEDICAID NO. (L2) **593043000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKESHORE INN NURSING HOME**
(L4) **108 8TH STREET NORTHWEST**
(L5) **WASECA, MN** (L6) **56093**

4. TYPE OF ACTION: 7 (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/08//2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

| | | | | |
|---|---|---|---|---|
| 01 Hospital | 05 HHA | 09 ESRD | 13 PTIP | 22 CLIA |
| 02 SNF/NF/Dual | 06 PRTF | 10 NF | 14 CORF | |
| 03 SNF/NF/Distinct | 07 X-Ray | 11 ICF/IID | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

**X** A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 55 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Gary Nederhoff, Unit Supervisor 09/22/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/22/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **09/17/2014** (L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

CMS Certification Number (CCN): 245388

September 22, 2014

Mr. Michael Corchran, Administrator
Lakeshore Inn Nursing Home
108 8th Street Northwest
Waseca, MN 56093

Dear Mr. Corchran:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 8, 2014 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
cc: Licensing and Certification File

*Protecting, Maintaining and Improving the Health of Minnesotans*

September 22, 2014

Mr. Michael Corchran, Administrator
Lakeshore Inn Nursing Home
108 8th Street Northwest
Waseca, Minnesota 56093

RE: Project Number S5388025

Dear Mr. Corchran:

On August 7, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 24, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On September 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 12, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 24, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 8, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 24, 2014, effective September 8, 2014 and therefore remedies outlined in our letter to you dated August 7, 2014, will not be imposed.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245388 | A. Building<br>B. Wing | 9/8/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| LAKESHORE INN NURSING HOME | 108 8TH STREET NORTHWEST<br>WASECA, MN 56093 |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix F0253<br>Reg. # 483.15(h)(2)<br>LSC | 08/29/2014 | ID Prefix F0279<br>Reg. # 483.20(d), 483.20(k)(1)<br>LSC | 08/29/2014 | ID Prefix F0282<br>Reg. # 483.20(k)(3)(ii)<br>LSC | 08/29/2014 |
| ID Prefix F0309<br>Reg. # 483.25<br>LSC | 08/29/2014 | ID Prefix F0312<br>Reg. # 483.25(a)(3)<br>LSC | 08/29/2014 | ID Prefix F0465<br>Reg. # 483.70(h)<br>LSC | 08/29/2014 |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By State Agency | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| | GPN/KFD | 09/22/2014 | 10160 | 09/08/2014 |
| Reviewed By CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

Followup to Survey Completed on: 7/24/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

**Department of Health and Human Services**
**Centers for Medicare & Medicaid Services**

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report

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| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction A. Building B. Wing | (Y3) Date of Revisit |
|---|---|---|
| 245388 | 01 - MAIN BUILDING 01 | 9/12/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| LAKESHORE INN NURSING HOME | 108 8TH STREET NORTHWEST<br>WASECA, MN 56093 |

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

| (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed | (Y4) Item | (Y5) Date Correction Completed |
|---|---|---|---|---|---|
| ID Prefix<br>Reg. # NFPA 101<br>LSC K0050 | 08/29/2014 | ID Prefix<br>Reg. # NFPA 101<br>LSC K0054 | 09/08/2014 | ID Prefix<br>Reg. # NFPA 101<br>LSC K0062 | 08/29/2014 |
| ID Prefix<br>Reg. # NFPA 101<br>LSC K0144 | 08/29/2014 | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |
| ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | | ID Prefix<br>Reg. #<br>LSC | |

| Reviewed By State Agency | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| | PS/KFD | 09/22/2014 | 25822 | 09/12/2014 |
| **Reviewed By CMS RO** | **Reviewed By** | **Date:** | **Signature of Surveyor:** | **Date:** |

**Followup to Survey Completed on:** 7/23/2014

**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

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

ID: 2V6G
Facility ID: 00682

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245388**

2. STATE VENDOR OR MEDICAID NO. (L2) **593043000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKESHORE INN NURSING HOME**
(L4) **108 8TH STREET NORTHWEST**
(L5) **WASECA, MN** (L6) **56093**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **07/24/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC 2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA
02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF
03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC
04 SNF 08 OPT/SP 12 RHC 16 HOSPICE

FISCAL YEAR ENDING DATE: (L35) **12/31**

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

**X** B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IID |
|---|---|---|---|---|
| | 55 | | | |
| (L37) | (L38) | (L39) | (L42) | (L43) |

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Connie Brady, HFE NE II 09/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/15/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7013 2250 0001 6356 5552

August 6, 2014

Mr. Michael Corchran, Administrator
Lakeshore Inn Nursing Home
108 8th Street Northwest
Waseca, Minnesota 56093

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5388024

Dear Mr. Corchran:

The above facility was surveyed on July 21, 2014 through July 24, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Office: (507) 537-7158
Fax: (507) 537-7194

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245388 | A. BUILDING ____ B. WING ____ | 07/24/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKESHORE INN NURSING HOME | 108 8TH STREET NORTHWEST WASECA, MN 56093 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 000 | INITIAL COMMENTS<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance.<br><br>Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. | F 000 | | |
| F 253 SS=D | 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES<br><br>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation and interview the facility failed to ensure a positioning device was maintained in good repair so it could be properly cleaned for 1 of 1 resident (R24) who had a lap buddy with exposed foam padding evident on all four edges of the device.<br><br>Findings include:<br><br>It was observed on 7/24/14, at 7:14 a.m. that R24 had a positioning device/lap buddy placed between the arms of the wheelchair which was in poor repair. R24 had the ability to place both arms and hands on top of the lap buddy to position the hands and/or arms. The foam padding located inside the vinyl covering was | F 253<br><br>9/3/14 GPN | R24's lap buddy was replaced. All frayed lap buddies have been discarded. New lap buddies were ordered. All nursing staff have been educated (via meeting and posted notes) to monitor equipment and report any items not in good repair.<br><br>DON or designee will monitor 10% of residents with lap buddies to ensure condition of lap buddy is in good repair. We will monitor the lap buddies monthly for 6 months. The results will be reported to the QI committee at their quarterly meetings. | 8/29 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 8/29/14

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.



RECEIVED
SEP 02 2014
Minnesota Department of Health
Marshall

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245388 | A. BUILDING ______ B. WING ______ | 07/24/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKESHORE INN NURSING HOME | 108 8TH STREET NORTHWEST WASECA, MN 56093 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| F 253 | Continued From page 1<br>exposed on the top and bottom edges of all four corners of this positioning device. An interview on 7/24/14, at 7:14 a.m. with nursing assistant (NA)-A during the observation of R24 verified the condition of the lap buddy.<br><br>It was observed on 7/21/14, at 5:15 p.m. that R24 independently consumed the evening meal while seated in the wheelchair with the attached lap buddy. During another observation on 7/22/14, at 12:30 p.m. R24 was seated in a geri-chair in the dining room and a towel, which contained spilled food, was noted tucked into the left side of the chair.<br><br>Interview on 7/23/14, at 3:15 p.m. with director of nursing (DON)-A and DON-B verified that R24 eats a lot of finger foods. During an interview on 7/24/14, at 7:21 a.m. with registered nurse (RN)-C, it was verified the lap buddy positioning device utilized by R24 had exposed foam padding evident on all four edges of the lap buddy. RN-C was noted to flip the lap buddy upside down to check whether the opposite surface was in good repair and noted that both sides of the device had exposed foam padding. The foam padding was protruding outside the vinyl covering. RN-C confirmed the resident care equipment could not be cleaned and properly sanitized and was in poor repair. It was verified this lap buddy was removed from the wheelchair and re-applied several times by staff throughout the day as necessary for R24. | F 253 | | |
| F 279 SS=D | 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS<br><br>A facility must use the results of the assessment to develop, review and revise the resident's | F 279 | | |



RECEIVED
SEP 02 2014
Minnesota Department of Health
Marshall

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245388 | A. BUILDING ______ B. WING ______ | 07/24/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKESHORE INN NURSING HOME | 108 8TH STREET NORTHWEST WASECA, MN 56093 |

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| F 279 | Continued From page 2<br>comprehensive plan of care.<br><br>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.<br><br>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review the facility failed to develop a coordinated plan of care with the hospice agency for 1 of 1 resident (R62) reviewed who had hospice services provided by a hospice agency.<br><br>Findings include:<br><br>Review of the facility face sheet identified R62 as being admitted to the facility on 4/4/14. Review of the nursing progress notes identified that R62 and was admitted to the hospice program on 6/24/14 with diagnosis of cachexia (wasting syndrome).<br><br>Review of R62's plan of care dated 7/2/14, identified that R62 had received end of life care | F 279 | The Hospice agency completed the Plan of Care for R62. The nursing staff and hospice discussed plan of care and continued collaboration in meeting resident's needs. The care plans were reviewed for completion of other residents who are utilizing hospice services.<br>The DON or her designee will monitor new hospice admissions to ensure collaboration between the facility and the hospice agency in development of the care plan, and to confirm the hospice agency's section is completed. | 8/29 |



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| F 279 | Continued From page 3<br>from hospice. The hospice plan of care located in the medical record was left blank.<br><br>During interview on 7/24, at 10:43 a.m. the director of nursing (DON) verified the hospice agency had not provided a care plan and the plan of care located in the medical record had not yet been filled out. She verified there should have been a plan of care developed between the facility and the hospice agency to coordinate care between the two entities. | F 279 | | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide grooming services according to the written plan of care for 2 of 3 residents (R19 & R24) reviewed who were dependent upon staff for grooming needs and failed to properly position 1 of 1 resident (R22) reviewed who was at risk for aspiration.<br><br>Findings include:<br><br>Review of the minimum data set (MD) dated 7/7/14, identified that R19 had the following diagnoses: dementia and Parkinson's disease.<br><br>Review of the plan of care for R19, dated 10/15/12, under the heading of Nurse Aide, | F 282 | R24's Care Plan has been updated. Approached added: monitor for need to change shirt throughout the day if soiled, monitor nails for cleanliness daily with cares, wash hands/face after every meal/snack, provide clothing protector with meals and as needed, check wheelchair daily for cleanliness and have housekeeping clean as needed.<br>R19's care plan has been updated to trim nails with bath as needed and monitor nails for sharp edges.<br>R22's care plan was reviewed. Therapy evaluated wheelchair positioning on 7/23/14. Resident was transferred into an upright wheelchair with a wedge cushion to assure proper positioning throughout the day as well as during meal times. Therapy provided instruction to staff and family on proper wheelchair positioning. This wheelchair has been effective and is now his primary chair. Speech Therapy evaluated resident during supper on 7/23/14. | 8/29 |



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| F 282 | Continued From page 4<br>specified: nail care with bath; and approaches for grooming and bathing included-extensive assist with 1 staff to assist. Review of the bath schedule identified that R19 received a bath every Thursday.<br><br>R19 was observed on 7/21/14, at 6:44 p.m. while seated in a wheelchair in her room. It was noted that R19 had untrimmed fingernails with very sharp edges. During an observation the following afternoon on 7/22/14, at 2:35 p.m. R19's fingernails remained untrimmed with sharp edges. It was observed again on 7/23/14, at 9:51 a.m. that R19's fingernails remained untrimmed with very sharp edges.<br><br>An interview was conducted on 7/24/14, at 7:19 a.m. with nursing assistant (NA)-A while observing the condition of R19's fingernails. NA-A verified that R19 had untrimmed fingernails with very sharp edges. The plan of care had not been followed as written.<br><br>Review of the minimum data set (MDS) identified that R24 had the following diagnoses: Lewy Body dementia and paralysis agitans (Parkinson's disease).<br><br>Review of the plan of care for R24, dated 2/15/13, under the heading of Nurse Aide, it identified: nail care with bath. The approach included-grooming: dependent upon 1 staff assist, staff washes face/hands, brushes teeth, shaves, combs hair and does peri-care; dressing: dependent upon 1 assist, staff dresses/undresses upper and lower body. Review of the bath schedule verified that R24 received a bath every Tuesday which would have been on 7/22/14. | F 282 | They noted congested cough well after the meal which Speech Therapist felt was not swallowing related. Speech Therapist made no changes to current diet or plan of care. A training memo has been posted in the employee dining room and on the wings for all employees that it is every department's responsibility to ensure proper grooming of residents. Any employee that sees a resident that is not properly groomed should notify the nurse<br><br>immediately.Nursing staff provided with review (via a training memo posted in the employee dining room and on the wings) of proper positioning techniques and precautions to take when feeding a resident who is at risk for aspiration. DON or designee will monitor 10% of the residents for proper grooming, wheelchair positioning, cushion placement, and proper positioning during meals. This will be done weekly for 4 weeks, semi-monthly for 2 months, and monthly for 3 months. The results will be reported and discussed at the QI meetings. | |



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| F 282 | Continued From page 5<br>During a telephone interview on 7/21/14, at 3:59 p.m. with R24's family member (F)-A it was learned that during frequent visits she noted the following: long and dirty fingernails, food stained clothing, unclean skin and at times seated in a soiled wheelchair.<br><br>It was observed on 7/21/14, at 2:03 p.m. and on 7/23/14, at 11:35 a.m. that R24 had long, dirty fingernails that were in need of grooming. During observation on the morning of 7/24/14, at 7:14 a.m. R24 was noted to have dirty, long fingernails even though the bath had been provided on 7/22/14, two days prior.<br><br>During another observation on 7/22/14, at 12:30 p.m. R24 was seated in a geri-chair in the dining room and a towel, which contained spilled food, was noted tucked into the left side of the chair and partially underneath R24. On 7/22/14, at 1:03 p.m. R24 was observed seated in a geri-chair in the hallway by the south nursing station wearing a shirt with spilled food on the front and was seated on an incontinence pad, stained a red color.<br><br>An interview on 7/23/14, at 3:15 p.m. with director of nursing (DON)-A and DON-B, it was verified that R24 eats a lot of finger foods which resulted in soiled fingernails.<br><br>An interview was conducted on 7/24/14, at 7:14 a.m. with nursing assistant (NA)-A during observation of R24. NA-A verified that R24 had dirty, long fingernails on both hands and R24's shirt had visible spilled liquid on it.<br><br>During an interview on 7/24/14, at 7:21 a.m. with registered nurse (RN)-C, it was also verified that | F 282 | | |



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| F 282 | Continued From page 6<br>R24 had dirty, long fingernails on both hands and the shirt had stained liquid. Subsequently, RN-C transported R24 into his room and changed the shirt.<br><br>R22 had diagnoses listed on the minimum data set (MDS) as noted: depression; Hx [history] of (L) [left] above the knee amputation (AKA) and diabetes.<br><br>The plan of care dated 5/6/14, was reviewed and the following was noted:<br>(1) Problem: Self Care Deficit: related to decreased mobility; Hx of (L) AKA; depression; and diabetes. Approach dated 4/30/13, Nurse Aide-Eating: Independent after staff provides tray set up.<br>(2) Problem dated 4/30/14: Potential trauma-falls injury related to impaired mobility; Hx of (L) above the knee amputation; impaired memory; depression; diabetes. Approach: dated (4/25/14) ....wedge cushion in wheelchair to prevent resident from sliding forward; and<br>(3) Problem dated 1/28/14: Potential for nutrition alteration. Approach: Assisted feeding table, may not be fed by a trained feeding assistant due to dysphagia.<br><br>Review of the flow sheet, which was identified as part of the July 2014 plan of care plan, identified the following orders from medical doctor (MD)-A: Aspiration precautions: (1.) Must be alert; (2.) Sit upright-all oral intake; (3.) Small bites/sips one at a time; (4.) Eat slowly; and (5.) Good oral care. The flow sheet listed treatments as: wedge cushion in w/c (wheelchair). The flow sheet was initialed by staff once on every shift from 7/1/14 thru 7/23/14, which indicated staff compliance with the physician orders as listed 1-5. | F 282 | | |



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| F 282 | Continued From page 7<br><br>During an observation on 7/21/14, at 5:15 p.m. in the dining room it was noted that R22 was seated in a geri-chair, in a reclined position. The geri-chair was reclined at approximately 50 degree angle. At 5:19 p.m. R22 was noted to cough repeatedly and cleared his airway after loose sounding phlegm was expectorated and swallowed. At 5:23 p.m. nursing assistant (NA)-C walked over to R22 and attempted to prop him forward by placing several pillows behind his back. It was observed that R22 remained reclined in the geri-chair but leaned to the left side after the application of the additional pillows. At 5:30 p.m. R22 was observed to consume a large leaf of lettuce and coughed repeatedly in an attempt to clear his airway.<br><br>On 7/22/14, at 8:10 a.m. R22 was observed while eating breakfast in the dining room and was again noted to be reclined in the geri chair at approximately a 50 degrees angle. While eating breakfast, R22 was noted to repeatedly cough. Trained medication aid (TMA)-B monitored R22 until the airway was cleared, and then left the immediate area.<br><br>During an observation on 7/22/14, at 12:20 p.m. R22 was seated in the reclined geri-chair during the noon meal. R22 received his food tray at 12:26 p.m. which consisted of chicken, crinkle cut sweet potato fries, broccoli salad and buttered bread. The chicken was cut up by NA-C and it was noted that R22 was able to feed himself without difficulty. At 12:33 p.m. R22 consumed a cold broccoli salad which contained large pieces of broccoli. R22 repeatedly coughed. At 12:48 p.m. R22 drank a sip of water, coughed repeatedly, cleared his airway. R22 continued to | F 282 | | |



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| F 282 | Continued From page 8<br>intermittently cough, with audible loose phlegm noted in his throat.<br><br>An observation on 7/23/14, at 8:00 a.m. was conducted while R22 was seated in a reclined geri-chair in the dining room. The geri-chair was again reclined to approximately a 50 degree angle. The meal consisted of french toast with syrup, sausage links, juice, water and coffee. R22 fed himself and no staff offered to cut up his food items. At 8:19 a.m. R22 was observed holding a fork which had an entire sausage link on it. R22 was identified to repeatedly cough and then cleared his airway. At 8:34 a.m. R22 appeared to be coughing. NA-D handed a glass of water to R22 because his water was out of his reach due to being in a reclined position.<br><br>An interview on 7/23/14, at 2:55 p.m. with DON-A and DON-B verified verified the plan of care had not been followed as written for R22 related to a wedge cushion in his wheel chair and the need for positioning in an upright wheel chair. | F 282 | | |
| F 309<br>SS=D | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document | F 309 | | |



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| F 309 | Continued From page 9<br>review the facility failed to provide proper positioning during meal time for 1 of 1 resident (R22) reviewed who was at risk for aspiration.<br><br>Findings include:<br><br>R22 had diagnoses listed on the minimum data set (MDS) as noted: depression; Hx [history] of (L) [left] above the knee amputation (AKA); depression; and diabetes.<br><br>During an observation on 7/21/14, at 5:15 p.m. in the dining room it was noted that R22 was seated in a geri-chair, in a reclined position. The geri-chair was reclined at approximately 50 degree angle. At 5:19 p.m. R22 was noted to cough repeatedly and cleared his airway after loose sounding phlegm was expectorated and swallowed. At 5:23 p.m. nursing assistant (NA)-C walked over to R22 and attempted to prop him forward by placing several pillows behind his back. It was observed that R22 remained reclined in the geri-chair but leaned to the left side after the application of the additional pillows. At 5:30 p.m. R22 was observed to consume a large leaf of lettuce and coughed repeatedly in an attempt to clear his airway.<br><br>On 7/22/14, at 8:10 a.m. R22 was observed while eating breakfast in the dining room and was again noted to be reclined in the geri chair at approximately a 50 degrees angle. While eating breakfast, R22 was noted to repeatedly cough. Trained medication aid (TMA)-B monitored R22 until the airway was cleared, and then left the immediate area.<br><br>During an observation on 7/22/14, at 12:20 p.m. R22 was seated in the reclined geri-chair during | F 309 | R22's care plan was reviewed. Therapy evaluated wheelchair positioning on 7/23/14. Resident was transferred into an upright wheelchair with a wedge cushion to assure proper positioning throughout the day as well as during meal times. Therapy provided instruction to staff and family on proper wheelchair positioning. This wheelchair has been effective and is now his primary chair. Speech Therapy evaluated resident during supper on 7/23/14. They noted congested cough well after the meal which Speech Therapist felt was not swallowing related. Speech Therapist made no changes to current diet or plan of care. Nursing staff provided with review (via a training memo posted in the employee dining room and on the wings) of proper positioning techniques and precautions to take when feeding a resident who is at risk for aspiration.<br>DON or designee will monitor 10% of the residents for proper grooming, wheelchair positioning, cushion placement, and proper positioning during meals. This will be done weekly for 4 weeks, semi-monthly for 2 months, and monthly for 3 months. The results will be reported and discussed at the QI meetings. | 8/29 |



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| F 309 | Continued From page 10<br>the noon meal. R22 received his food tray at 12:26 p.m. which consisted of chicken, crinkle cut sweet potato fries, broccoli salad and buttered bread. The chicken was cut up by NA-C and it was noted that R22 was able to feed himself without difficulty. At 12:33 p.m. R22 consumed a cold broccoli salad which contained large pieces of broccoli. R22 repeatedly coughed throughout the meal. At 12:48 p.m. R22 drank a sip of water, coughed repeatedly and cleared his airway. R22 continued to intermittently cough, with audible loose phlegm noted in his throat.<br><br>An observation on 7/23/14, at 8:00 a.m. was conducted while R22 was seated in a reclined geri-chair in the dining room at the assisted feeding table with staff present. The geri-chair was again reclined to approximately a 50 degree angle. The meal consisted of french toast with syrup, sausage links, juice, water and coffee. R22 fed himself and no staff offered to cut up his food items. At 8:19 a.m. R22 was observed holding a fork which had an entire sausage link on it. R22 was identified to repeatedly cough and then cleared his airway. At 8:34 a.m. R22 appeared to be coughing and not clearing the phlegm so NA-D handed a glass of water to R22 because his water was not within reach due to being in a reclined position.<br><br>Review of the occupational therapy (OT) discharge summary dated 2/27/14 thru 3/12/14, identified that R22 "was seen again this week to determine if there was any change in feeding status". "Res. [resident] continues to be able to feed self independently with standard silverware". Occupation Therapy Evaluation dated 11/1/13 identified the following under the Summary Statement: Nursing reported Pt. [patient]sliding | F 309 | | |



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| F 309 | Continued From page 11 | F 309 | | |

forward in w/c [wheelchair] and needs new w/c set up to prevent sliding out of wheelchair. The Short Term Goal was: Pt. will tolerate new w/c set up to prevent sliding out of w/c. The Long Term Care Goal was: pt. will demonstrate upright positioning in w/c. Pt./Family Goal: Upright in w/c. Another review of OT notes dated 11/1/13 thru 11/12/13 verified that R22 "was seen 3x [3 times] for w/c positioning". "Pt now sitting upright in w/c with no more concerns from nursing". "Pt was sliding forward in w/c". "Pt was given new w/c cushion which promotes upright position". "no more concerns with sliding forward".

R22 was observed on 7/23/14, at 11:30 a.m. as being seated in an upright wheelchair and not positioned in the geri-chair as noted previously. R22 was seated on a ROHO (a nylon type fabric covered cushion that distributes weight evenly to prevent skin breakdown) cushion that had a dysum (a thin pad that would prevent the ROHO cushion from sliding forward) located underneath the cushion. Although the dysum prevented the ROHO cushion from sliding forward in the wheelchair, a covering was absent from the nylon ROHO cushion and the slippery surface did not prevent R22 from sliding forward in the wheelchair.

During an interview on 7/23/14, at 11:35 a.m. NA-A, indicated that every Wednesday during the noon meal, R22 was positioned into a high back wheelchair and not the geri-chair as family member (F)-A comes to visit and dine with R22. NA-A further added that F-A transports R22 around the facility following the noon meal and the high back wheelchair was easier to maneuver than the geri chair. When questioned regarding the rationale for utilizing the reclining geri-chair for



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| F 309 | Continued From page 12<br>all other meals, NA-A stated,."I don't know, maybe because it's easier for him to relax?"<br><br>The care area assessment (CAA's) for R22 dated 4/25/14 was reviewed and the #11- Fall documentation identified: wedge cushion in wheelchair to prevent resident from sliding forward. The # 12-Nutrition CAA documentation dated 4/29/14 identified: proper positioning in wheelchair/chair for dining due to.....dysphagia [difficulty swallowing].<br><br>The plan of care dated 5/6/14, was reviewed and the following was noted:<br>(1) Problem: Self Care Deficit: related to decreased mobility; depression; Hx [history] of (L) [left] above the knee amputation; depression; and diabetes. Approach dated 4/30/13 Nurse Aide-Eating: Independent after staff provides tray set up.<br>(2) Problem dated 4/30/14: Potential trauma-falls injury related to impaired mobility; Hx of (L) above the knee amputation; impaired memory; depression; diabetes. Approach: dated (4/25/14) ....wedge cushion in wheelchair to prevent resident from sliding forward; and<br>(3) Problem dated 1/28/14: Potential for nutrition alteration. Approach: Assisted feeding table, may not be fed by a trained feeding assistant due to dysphagia.<br><br>Review of the flow sheet, which was identified as part of the July 2014 plan of care plan, identified the following orders from medical doctor (MD)-A: Aspiration precautions: (1.) Must be alert; (2.) Sit upright-all oral intake; (3.) Small bites/sips one at a time; (4.) Eat slowly; and (5.) Good oral care. The flow sheet listed treatments as: wedge cushion in w/c (wheelchair). The flow sheet was | F 309 | | |



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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245388 | A. BUILDING ____ B. WING ____ | 07/24/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKESHORE INN NURSING HOME | 108 8TH STREET NORTHWEST WASECA, MN 56093 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 309 | Continued From page 13<br>initialed by staff once on every shift from 7/1/14 thru 7/23/14, which indicated staff compliance with the physician orders as listed 1-5.<br><br>During an observation on 7/23/14, at 9:25 a.m. R22 was located in his room and there was both a high back wheelchair and a reclining geri-chair. No wedge cushion was evident in either chair but the ROHO cushion was present.<br><br>Review of orders dated and signed 6/18/14, by certified nurse practitioner (CNP)-A identified the following under the Cumulative Diagnosis List: Dysphagia. An interview was conducted on 7/23/14, at 10:55 a.m. with CNP-A and it was stated with a dyphagia diagnosis, the reclined position while in the geri-chair could put R22 at risk for aspiration pneumonia.<br><br>During an interview on 7/23/14, at 12:00 noon F-A verified she had been aware of R22's choking risk. She further added that staff position R22 in a reclining geri-chair due to a tendency of R22 to wiggle while seated and staff were afraid of a fall. She denied any knowledge the wedge cushion had been utilized in either the wheelchair or geri-chair.<br><br>During a telephone interview on 7/23/14, at 9:11 a.m. speech language pathologist (SLP)-A verified that R22 had not been seen nor evaluated by speech therapy (ST) for years.<br><br>An interview on 7/23/14, at 2:55 p.m. with DON-A and DON-B verified they needed to discuss with CNP-A the need to conduct a swallow evaluation due to the risk of aspiration and the need for an occupational therapy evaluation related to the use of a wedge cushion in the straight back | F 309 | | |



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| LAKESHORE INN NURSING HOME | 108 8TH STREET NORTHWEST WASECA, MN 56093 |

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| F 309 | Continued From page 14 wheelchair. DON-A and DON-B further verified the plan of care had not been followed as written for R22 related to a wedge cushion in his wheel chair and/or the need for positioning in an upright wheel chair. | F 309 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide personal nail care and grooming for 2 of 3 residents (R19 & R24) reviewed who were dependent upon staff for nail grooming needs and personal hygiene needs.<br><br>Findings include:<br><br>Review of the minimum data set (MD) dated 7/7/14, identified that R19 had the following diagnoses: dementia and Parkinson's disease. R19 was observed on 7/21/14, at 6:44 p.m. while seated in a wheelchair in her room. It was noted that R19 had untrimmed fingernails with very sharp edges. During an observation the following afternoon on 7/22/14, at 2:35 p.m. R19's fingernails remained untrimmed with sharp edges. It was observed again on 7/23/14, at 9:51 a.m. that R19's fingernails remained untrimmed with very sharp edges. | F 312 | R24's Care Plan has been updated. Approached added: monitor for need to change shirt throughout the day if soiled, monitor nails for cleanliness daily with cares, wash hands/face after every meal/snack, provide clothing protector with meals and as needed, check wheelchair daily for cleanliness and have housekeeping clean as needed. R19's care plan has been updated to trim nails with bath as needed and monitor nails for sharp edges.<br>A training memo has been posted in the employee dining room and on the wings for all employees that it is every department's responsibility to ensure proper grooming of residents. Any employee that sees a resident that is not properly groomed should notify the nurse immediately.<br>DON or designee will monitor 10% of the residents for proper grooming, wheelchair positioning, cushion placement, and proper positioning during meals. This will be done weekly for 4 weeks, semi-monthly for 2 months, and monthly for 3 months. The results will be reported and discussed at the QI meetings. | 8/29 |



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| | 245388 | A. BUILDING ______ B. WING ______ | 07/24/2014 |

NAME OF PROVIDER OR SUPPLIER: LAKESHORE INN NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 108 8TH STREET NORTHWEST, WASECA, MN 56093

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| F 312 | Continued From page 15<br><br>Review of the plan of care dated 10/15/12, under the heading of Nurse Aide, it specified: nail care with bath; Approaches for grooming and bathing included-extensive assist with 1 staff to assist. Review of the bath schedule identified that R19 received a bath every Thursday.<br><br>An interview was conducted on 7/24/14, at 7:19 a.m. with nursing assistant (NA)-A while observing the condition of R19's fingernails. NA-A verified that R19 had untrimmed fingernails with very sharp edges.<br><br>Review of the MDS identified that R24 had the following diagnoses: Lewy Body dementia and paralysis agitans (Parkinson's disease).<br><br>During a telephone interview on 7/21/14, at 3:59 p.m. with R24's family member (F)-A it was learned that during frequent visits she noted the following: long and dirty fingernails, food stained clothing, unclean skin and at times seated in a soiled wheelchair.<br><br>It was observed on 7/21/14, at 2:03 p.m. and on 7/23/14, at 11:35 a.m. that R24 had long, dirty fingernails that were in need of grooming. During observation on the morning of 7/24/14, at 7:14 a.m. R24 was noted to have dirty, long fingernails even though the bath had been provided on 7/22/14, two days prior.<br><br>During another observation on 7/22/14, at 12:30 p.m. R24 was seated in a geri-chair in the dining room and a towel, which contained spilled food, was noted tucked into the left side of the chair and partially underneath R24. On 7/22/14, at 1:03 p.m. R24 was observed seated in a | F 312 | | |



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| F 312 | Continued From page 16<br>geri-chair in the hallway by the south nursing station wearing a shirt with spilled food on the front and seated on a visible incontinence pad stained in a reddish color.<br><br>An interview on 7/23/14, at 3:15 p.m. with director of nursing (DON)-A and DON-B verified that R24 eats a lot of finger foods which resulted in soiled fingernails frequently.<br><br>An interview was conducted on 7/24/14, at 7:14 a.m. with nursing assistant (NA)-A during observation of R24. NA-A verified that R24 had dirty, long fingernails on both hands and R24's shirt had spilled liquid on it.<br><br>During an interview on 7/24/14, at 7:21 a.m. with registered nurse (RN)-C, it was also verified that R24 had dirty, long fingernails on both hands and the shirt had visible spilled liquid on it. Subsequently, RN-C transported R24 to his room and changed the soiled shirt.<br><br>Review of the plan of care dated 2/15/13, under the heading of Nurse Aide, it identified: nail care with bath; Approach-grooming: dependent upon 1 assist, staff washes face/hands, brushes teeth, shaves, combs hair and does peri-care; dressing: dependent upon 1 assist, staff dresses/undresses upper and lower body. Review of the bath schedule verified that R24 received a bath every Tuesday and had received a bath on Tuesday, 722/14.<br><br>A policy on nail care and grooming was requested on 7/24/14, at 10:02 a.m. and (DON)-B stated that she was not able to locate any such policy. | F 312 | | |
| F 465 | 483.70(h) | F 465 | | |



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| F 465 SS=C | Continued From page 17<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to maintain the cleanliness of the carpet located in the front entry and down the hallway into the dining room area. This had the potential to affect all 49 residents who routinely access this multi-use area for activities, dining and family visits.<br><br>Findings include:<br><br>During observations on all days of the survey 7/21, at 2:00 p.m. 7/22, 7/23, at 9:30 a.m. and 7/24, it was noted that the carpet leading from the front entryway into the dining room appeared heavily soiled. A soiled pathway was noted down the center of the carpet.<br><br>During an interview on 7/23/14, at 9:30 a.m. the environmental director (ED) reported the housekeeping supervisor (HS) was in charge of the carpet cleaning. During an follow-up interview on 7/23/14, at 10:25 a.m. with the HS, she verified the carpet in the entry and down the hallway into the dining area was heavily soiled. The HS stated that utility carts were routinely transported from the dietary/staff utility room door and wheeled adjacent to the main kitchen entry door, which caused the soiled path noted on the carpet. The carpet cleaning schedule was | F 465 | F465<br>The carpet was cleaned with a new cleaner and new method. So far the new method is working well. If that stops being the case, we will look at other solutions. Housekeeping will put notes in the communication book for anybody to report any soiled areas. Housekeeping will clean any soiled carpet that is reported or noted by housekeeping staff. Housekeeping director, or designee will monitor high traffic areas of carpet daily for a month, weekly for 3 months and monthly for 2 months. The results will be discussed at the QI meetings. | 8/29 |



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| F 465 | Continued From page 18<br>reviewed with the HS and it was noted that although the carpets had been cleaned every 5 to 7 days over the past month, the carpets remained heavily soiled. | F 465 | | |



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PRINTED: 08/06/2014
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245388 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING ______ | 07/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKESHORE INN NURSING HOME | 108 8TH STREET NORTHWEST<br>WASECA, MN 56093 |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.<br><br>UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Lakeshore Inn Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.<br><br>PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES ( K-TAGS) TO:<br><br>Health Care Fire Inspections<br>State Fire Marshal Division<br>445 Minnesota St., Suite 145<br>St Paul, MN 55101-5145, or | K 000 | POC ok<br>PB 9-9-14<br><br>RECEIVED<br>SEP - 8 2014<br>MN DEPT. OF PUBLIC SAFETY<br>STATE FIRE MARSHAL DIVISION | |

EXIT: 7-23-14 DC 9-8-14

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | ADMINISTRATOR | 8/29/14 |

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

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|---|---|---|---|
| | 245386 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING ______ | 07/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKESHORE INN NURSING HOME | 108 8TH STREET NORTHWEST<br>WASECA, MN 56093 |

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|---|---|---|---|---|
| K 000 | Continued From page 1<br>By email to: Marian.Whitney@state.mn.us<br><br>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:<br><br>1. A description of what has been, or will be, done to correct the deficiency.<br><br>2. The actual, or proposed, completion date.<br><br>3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.<br><br>Lake Shore Inn Nursing Home is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1960 and was determined to be of Type II(111) construction. In 1968, addition was constructed to the South Wing that was determined to be of Type II(111) construction. In 1984, another addition was added to the South Wing and was determined to be Type II (111). In 1998, an addition was added to the East Wing and was determined to be Type II (111) construction. Because the original building and the 3 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.<br><br>The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.<br><br>The facility has a capacity of 55 beds and had a | K 000 | | |

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| | 245388 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING ______ | 07/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| K 000 | Continued From page 2<br>census of 49 at the time of the survey.<br><br>The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by: | K 000 | | |
| K 050<br>SS=D | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2<br><br>This STANDARD is not met as evidenced by:<br>Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 49 residents.<br><br>Findings include:<br><br>On facility tour between 9:00 AM and 12 noon on 07/23/2014, the review of the fire drill documentation for the past 12 months (August 2013 to July 2014) revealed the drills for the following shifts were completed but did not sufficiently vary the times that the drills were conducted: | K 050 | Fire drills times will be more randomized so that staff doesn't know when to expect a drill and must be prepared at all times. Director of Maintenance, or designee will be responsible. Results will be reported to the QI committee quarterly for a year. | 8/29 |

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| K 050 | Continued From page 3<br><br>Evening: 1840, 1930, 1520 and 1910 hours<br>Night: 0220, 0130, 0400 and 0130 hours<br><br>This deficient practice was confirmed by the Administrator (MC) at the time of discovery. | K 050 | | |
| K 054<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3<br><br>This STANDARD is not met as evidenced by:<br>Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirement 1999 NFPA 72, Section 7-3.2. The deficient practice could affect all 49 residents.<br><br>Findings include:<br><br>On facility tour between 9:00 AM and 12 noon on 07/23/2014, the review of the annual inspection report of the fire alarm system from Flex-Comm Security dated 2/6/14. The sensitivity was recorded for each smoke detector and were in the range of .62 to .64. The the factory range was not included on the above report. I reviewed the annual report dated 2/9/2010, the factory sensitivity range was included on this report. The report indicated the smoke detectors should be in the range of 1.0 to 4.0. So according to the 2/6/14 sensitivity report all the detectors failed. | K 054 | Our alarm monitoring company had a typo on the form regarding the sensitivity of the smoke alarms. The company will be re-evaluating the sensitivity of the alarms as soon as possible. We are coordinating a time that this can be done.<br>Director of maintenance, or designee will ensure that this work is done in a timely fashion. The work done will be reported to the QI committee once completed. | 9-8-14<br>~~9/30~~ |

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| LAKESHORE INN NURSING HOME | 108 8TH STREET NORTHWEST<br>WASECA, MN 56093 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| K 054 | Continued From page 4<br><br>This deficient practice was confirmed by the Administrator (MC) at the time of discovery. | K 054 | | |
| K 062<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, sections 2-3.2 and 2-3.3. This deficient practice could affect all 49 residents.<br><br>Findings include:<br><br>On facility tour between 9:00 AM and 12 noon on 07/23/2014, a review of the annual fire sprinkler inspection records revealed the following:<br><br>1. No documentation for the 2013 - 4th quarter and 2014 - 1st quarter fire sprinkler quarterly flow tests<br><br>2. The water gauge on the main riser has a hand written date of 2-06. There was no documentation stating the gauge has been calibrated or replaced in the past 5 years | K 062 | The documentation of the sprinkler flow tests was not completed properly. The paperwork is filled out now.<br>The Director of Maintenance or his designee will put this test on his quarterly test checklist. These tests have always been done, but the paperwork has been lacking.<br>The updated checklist will be given to the QI committee to review for accuracy.<br>The water gauge on the main riser needs to be replaced every five years, ours was out of compliance. The Director of Maintenance has contacted a contractor to replace the gauge. | 8/29 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245386 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 07/23/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LAKESHORE INN NURSING HOME | 108 8TH STREET NORTHWEST<br>WASECA, MN 56093 |

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|---|---|---|---|---|
| K 062 | Continued From page 5<br>These deficient practices were confirmed by the Administrator (MC) at the time of discovery. | K 062 | | |
| K 144<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.<br><br>This STANDARD is not met as evidenced by:<br>Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 49 residents.<br><br>Findings include:<br><br>On facility tour between 9:00 AM and 12 noon on 07/23/2014, documentation review of the weekly inspection logs (July 2013 to July 2014) for the diesel emergency generator revealed that the weekly operational inspection were missed for the weeks of 9/2/13,11/25/13 and 5/26/14.<br><br>This deficient practice was confirmed by the Administrator (MC) at the time of discovery. | K 144 | Our weekly load test for the generator was not completed a couple of times throughout the last year. The maintenance staff misunderstood how the test could be done. The test is now being done every week. The staff have been educated as to how and when the test can be completed. | 8/29 |

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|---|---|---|---|
| | 245388 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING ______ | 07/23/2014 |

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| K 144 | Continued From page 6<br><br>*TEAM COMPOSITION*<br>Gary Schroeder, Life Safety Code Spc. | K 144 | | |

*Protecting, Maintaining and Improving the Health of Minnesotans*

Certified Mail # 7013 2250 0001 6356 5552

August 7, 2014

Mr. Michael Corchran, Administrator
Lakeshore Inn Nursing Home
108 8th Street Northwest
Waseca, Minnesota 56093

RE: Project Number S5388024

Dear Mr. Corchran:

On July 24, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

**DEPARTMENT CONTACT**

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

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street
Marshall, MN 56258
Office: (507) 537-7158
Fax: (507) 537-7194

**OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 2, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 2, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

**PLAN OF CORRECTION (PoC)**

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Include signature of provider and date.

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

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

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

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

**PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE**

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

**VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

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

**Original deficiencies not corrected**

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

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

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

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

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

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

If substantial compliance with the regulations is not verified by October 24, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 24, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

**INFORMAL DISPUTE RESOLUTION**

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Minnesota Department of Health

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00682 | A. BUILDING: ______<br>B. WING ______ | 07/24/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKESHORE INN NURSING HOME** | **108 8TH STREET NORTHWEST<br>WASECA, MN 56093** |

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|---|---|---|---|---|
| 2 000 | Initial Comments<br><br>*****ATTENTION******<br><br>NH LICENSING CORRECTION ORDER<br><br>In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.<br><br>Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.<br><br>You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.<br><br>INITIAL COMMENTS:<br>On July 21st, 22nd, 23rd and 24th, 2014, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date on the bottom of the first page in the line marked with "Laboratory Director's or Provider/Supplier Representative's | 2 000 | Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. | |

Minnesota Department of Health
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: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00682 | A. BUILDING: ______ B. WING ______ | 07/24/2014 |

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|---|---|---|---|---|
| 2 000 | Continued From page 1<br><br>signature." Make a copy of these orders for your records and return the original to the address below: Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program, 1400 E. Lyon Street, Marshall, MN 56258<br><br>Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.<br><br>The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | 2 000 | The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.<br><br>PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.<br><br>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. | |
| 2 565 | MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use<br><br>Subp. 3. Use. A comprehensive plan of care | 2 565 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| 2 565 | Continued From page 2 | 2 565 | | |

must be used by all personnel involved in the care of the resident.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review the facility failed to provide grooming services according to the written plan of care for 2 of 3 residents (R19 & R24) reviewed who were dependent upon staff for grooming needs and failed to properly position 1 of 1 resident (R22) reviewed who was at risk for aspiration.

Findings include:

Review of the minimum data set (MD) dated 7/7/14, identified that R19 had the following diagnoses: dementia and Parkinson's disease.

Review of the plan of care for R19, dated 10/15/12, under the heading of Nurse Aide, specified: nail care with bath; and approaches for grooming and bathing included-extensive assist with 1 staff to assist. Review of the bath schedule identified that R19 received a bath every Thursday.

R19 was observed on 7/21/14, at 6:44 p.m. while seated in a wheelchair in her room. It was noted that R19 had untrimmed fingernails with very sharp edges. During an observation the following afternoon on 7/22/14, at 2:35 p.m. R19's fingernails remained untrimmed with sharp edges. It was observed again on 7/23/14, at 9:51 a.m. that R19's fingernails remained untrimmed with very sharp edges.

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| | 00682 | A. BUILDING: ____ B. WING ____ | 07/24/2014 |

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| 2 565 | Continued From page 3 | 2 565 | | |

An interview was conducted on 7/24/14, at 7:19 a.m. with nursing assistant (NA)-A while observing the condition of R19's fingernails. NA-A verified that R19 had untrimmed fingernails with very sharp edges. The plan of care had not been followed as written.

Review of the minimum data set (MDS) identified that R24 had the following diagnoses: Lewy Body dementia and paralysis agitans (Parkinson's disease).

Review of the plan of care for R24, dated 2/15/13, under the heading of Nurse Aide, it identified: nail care with bath. The approach included-grooming: dependent upon 1 staff assist, staff washes face/hands, brushes teeth, shaves, combs hair and does peri-care; dressing: dependent upon 1 assist, staff dresses/undresses upper and lower body. Review of the bath schedule verified that R24 received a bath every Tuesday which would have been on 7/22/14.

During a telephone interview on 7/21/14, at 3:59 p.m. with R24's family member (F)-A it was learned that during frequent visits she noted the following: long and dirty fingernails, food stained clothing, unclean skin and at times seated in a soiled wheelchair.

It was observed on 7/21/14, at 2:03 p.m. and on 7/23/14, at 11:35 a.m. that R24 had long, dirty fingernails that were in need of grooming. During observation on the morning of 7/24/14, at 7:14 a.m. R24 was noted to have dirty, long fingernails even though the bath had been provided on 7/22/14, two days prior.

During another observation on 7/22/14, at 12:30 p.m. R24 was seated in a geri-chair in the dining

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| 2 565 | Continued From page 4 | 2 565 | | |

room and a towel, which contained spilled food, was noted tucked into the left side of the chair and partially underneath R24. On 7/22/14, at 1:03 p.m. R24 was observed seated in a geri-chair in the hallway by the south nursing station wearing a shirt with spilled food on the front and was seated on an incontinence pad, stained a red color.

An interview on 7/23/14, at 3:15 p.m. with director of nursing (DON)-A and DON-B, it was verified that R24 eats a lot of finger foods which resulted in soiled fingernails.

An interview was conducted on 7/24/14, at 7:14 a.m. with nursing assistant (NA)-A during observation of R24. NA-A verified that R24 had dirty, long fingernails on both hands and R24's shirt had visible spilled liquid on it.

During an interview on 7/24/14, at 7:21 a.m. with registered nurse (RN)-C, it was also verified that R24 had dirty, long fingernails on both hands and the shirt had stained liquid. Subsequently, RN-C transported R24 into his room and changed the shirt.

R22 had diagnoses listed on the minimum data set (MDS) as noted: depression; Hx [history] of (L) [left] above the knee amputation (AKA) and diabetes.

The plan of care dated 5/6/14, was reviewed and the following was noted:
(1) Problem: Self Care Deficit: related to decreased mobility; Hx of (L) AKA; depression; and diabetes. Approach dated 4/30/13, Nurse Aide-Eating: Independent after staff provides tray set up.
(2) Problem dated 4/30/14: Potential

Minnesota Department of Health

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| 2 565 | Continued From page 5<br>trauma-falls injury related to impaired mobility; Hx of (L) above the knee amputation; impaired memory; depression; diabetes. Approach: dated (4/25/14) ....wedge cushion in wheelchair to prevent resident from sliding forward; and (3) Problem dated 1/28/14: Potential for nutrition alteration. Approach: Assisted feeding table, may not be fed by a trained feeding assistant due to dysphagia.<br><br>Review of the flow sheet, which was identified as part of the July 2014 plan of care plan, identified the following orders from medical doctor (MD)-A: Aspiration precautions: (1.) Must be alert; (2.) Sit upright-all oral intake; (3.) Small bites/sips one at a time; (4.) Eat slowly; and (5.) Good oral care. The flow sheet listed treatments as: wedge cushion in w/c (wheelchair). The flow sheet was initialed by staff once on every shift from 7/1/14 thru 7/23/14, which indicated staff compliance with the physician orders as listed 1-5.<br><br>During an observation on 7/21/14, at 5:15 p.m. in the dining room it was noted that R22 was seated in a geri-chair, in a reclined position. The geri-chair was reclined at approximately 50 degree angle. At 5:19 p.m. R22 was noted to cough repeatedly and cleared his airway after loose sounding phlegm was expectorated and swallowed. At 5:23 p.m. nursing assistant (NA)-C walked over to R22 and attempted to prop him forward by placing several pillows behind his back. It was observed that R22 remained reclined in the geri-chair but leaned to the left side after the application of the additional pillows. At 5:30 p.m. R22 was observed to consume a large leaf of lettuce and coughed repeatedly in an attempt to clear his airway.<br><br>On 7/22/14, at 8:10 a.m. R22 was observed while | 2 565 | | |

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| 2 565 | Continued From page 6 | 2 565 | | |

eating breakfast in the dining room and was again noted to be reclined in the geri chair at approximately a 50 degrees angle. While eating breakfast, R22 was noted to repeatedly cough. Trained medication aid (TMA)-B monitored R22 until the airway was cleared, and then left the immediate area.

During an observation on 7/22/14, at 12:20 p.m. R22 was seated in the reclined geri-chair during the noon meal. R22 received his food tray at 12:26 p.m. which consisted of chicken, crinkle cut sweet potato fries, broccoli salad and buttered bread. The chicken was cut up by NA-C and it was noted that R22 was able to feed himself without difficulty. At 12:33 p.m. R22 consumed a cold broccoli salad which contained large pieces of broccoli. R22 repeatedly coughed. At 12:48 p.m. R22 drank a sip of water, coughed repeatedly, cleared his airway. R22 continued to intermittently cough, with audible loose phlegm noted in his throat.

An observation on 7/23/14, at 8:00 a.m. was conducted while R22 was seated in a reclined geri-chair in the dining room. The geri-chair was again reclined to approximately a 50 degree angle. The meal consisted of french toast with syrup, sausage links, juice, water and coffee. R22 fed himself and no staff offered to cut up his food items. At 8:19 a.m. R22 was observed holding a fork which had an entire sausage link on it. R22 was identified to repeatedly cough and then cleared his airway. At 8:34 a.m. R22 appeared to be coughing. NA-D handed a glass of water to R22 because his water was out of his reach due to being in a reclined position.

An interview on 7/23/14, at 2:55 p.m. with DON-A and DON-B verified verified the plan of care had

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| 2 565 | Continued From page 7<br>not been followed as written for R22 related to a wedge cushion in his wheel chair and the need for positioning in an upright wheel chair.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. The director of nursing or designee could monitor for compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 565 | | |
| 2 830 | MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General<br><br>Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide proper positioning during meal time for 1 of 1 resident (R22) reviewed who was at risk for aspiration. | 2 830 | | |

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| 2 830 | Continued From page 8 | 2 830 | | |

Findings include:

R22 had diagnoses listed on the minimum data set (MDS) as noted: depression; Hx [history] of (L) [left] above the knee amputation (AKA); depression; and diabetes.

During an observation on 7/21/14, at 5:15 p.m. in the dining room it was noted that R22 was seated in a geri-chair, in a reclined position. The geri-chair was reclined at approximately 50 degree angle. At 5:19 p.m. R22 was noted to cough repeatedly and cleared his airway after loose sounding phlegm was expectorated and swallowed. At 5:23 p.m. nursing assistant (NA)-C walked over to R22 and attempted to prop him forward by placing several pillows behind his back. It was observed that R22 remained reclined in the geri-chair but leaned to the left side after the application of the additional pillows. At 5:30 p.m. R22 was observed to consume a large leaf of lettuce and coughed repeatedly in an attempt to clear his airway.

On 7/22/14, at 8:10 a.m. R22 was observed while eating breakfast in the dining room and was again noted to be reclined in the geri chair at approximately a 50 degrees angle. While eating breakfast, R22 was noted to repeatedly cough. Trained medication aid (TMA)-B monitored R22 until the airway was cleared, and then left the immediate area.

During an observation on 7/22/14, at 12:20 p.m. R22 was seated in the reclined geri-chair during the noon meal. R22 received his food tray at 12:26 p.m. which consisted of chicken, crinkle cut sweet potato fries, broccoli salad and buttered bread. The chicken was cut up by NA-C and it

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was noted that R22 was able to feed himself without difficulty. At 12:33 p.m. R22 consumed a cold broccoli salad which contained large pieces of broccoli. R22 repeatedly coughed throughout the meal. At 12:48 p.m. R22 drank a sip of water, coughed repeatedly and cleared his airway. R22 continued to intermittently cough, with audible loose phlegm noted in his throat.

An observation on 7/23/14, at 8:00 a.m. was conducted while R22 was seated in a reclined geri-chair in the dining room at the assisted feeding table with staff present. The geri-chair was again reclined to approximately a 50 degree angle. The meal consisted of french toast with syrup, sausage links, juice, water and coffee. R22 fed himself and no staff offered to cut up his food items. At 8:19 a.m. R22 was observed holding a fork which had an entire sausage link on it. R22 was identified to repeatedly cough and then cleared his airway. At 8:34 a.m. R22 appeared to be coughing and not clearing the phlegm so NA-D handed a glass of water to R22 because his water was not within reach due to being in a reclined position.

Review of the occupational therapy (OT) discharge summary dated 2/27/14 thru 3/12/14, identified that R22 "was seen again this week to determine if there was any change in feeding status". "Res. [resident] continues to be able to feed self independently with standard silverware". Occupation Therapy Evaluation dated 11/1/13 identified the following under the Summary Statement: Nursing reported Pt. [patient]sliding forward in w/c [wheelchair] and needs new w/c set up to prevent sliding out of wheelchair. The Short Term Goal was: Pt. will tolerate new w/c set up to prevent sliding out of w/c. The Long Term Care Goal was: pt. will demonstrate upright

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positioning in w/c. Pt./Family Goal: Upright in w/c. Another review of OT notes dated 11/1/13 thru 11/12/13 verified that R22 "was seen 3x [3 times] for w/c positioning". "Pt now sitting upright in w/c with no more concerns from nursing". "Pt was sliding forward in w/c". "Pt was given new w/c cushion which promotes upright position". "no more concerns with sliding forward".

R22 was observed on 7/23/14, at 11:30 a.m. as being seated in an upright wheelchair and not positioned in the geri-chair as noted previously. R22 was seated on a ROHO (a nylon type fabric covered cushion that distributes weight evenly to prevent skin breakdown) cushion that had a dysum (a thin pad that would prevent the ROHO cushion from sliding forward) located underneath the cushion. Although the dysum prevented the ROHO cushion from sliding forward in the wheelchair, a covering was absent from the nylon ROHO cushion and the slippery surface did not prevent R22 from sliding forward in the wheelchair.

During an interview on 7/23/14, at 11:35 a.m. NA-A, indicated that every Wednesday during the noon meal, R22 was positioned into a high back wheelchair and not the geri-chair as family member (F)-A comes to visit and dine with R22. NA-A further added that F-A transports R22 around the facility following the noon meal and the high back wheelchair was easier to maneuver than the geri chair. When questioned regarding the rationale for utilizing the reclining geri-chair for all other meals, NA-A stated, "I don't know, maybe because it's easier for him to relax?"

The care area assessment (CAA's) for R22 dated 4/25/14 was reviewed and the #11- Fall documentation identified: wedge cushion in

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wheelchair to prevent resident from sliding forward. The # 12-Nutrition CAA documentation dated 4/29/14 identified: proper positioning in wheelchair/chair for dining due to.....dysphagia [difficulty swallowing].

The plan of care dated 5/6/14, was reviewed and the following was noted:
(1) Problem: Self Care Deficit: related to decreased mobility; depression; Hx [history] of (L) [left] above the knee amputation; depression; and diabetes. Approach dated 4/30/13 Nurse Aide-Eating: Independent after staff provides tray set up.
(2) Problem dated 4/30/14: Potential trauma-falls injury related to impaired mobility; Hx of (L) above the knee amputation; impaired memory; depression; diabetes. Approach: dated (4/25/14) ....wedge cushion in wheelchair to prevent resident from sliding forward; and
(3) Problem dated 1/28/14: Potential for nutrition alteration. Approach: Assisted feeding table, may not be fed by a trained feeding assistant due to dysphagia.

Review of the flow sheet, which was identified as part of the July 2014 plan of care plan, identified the following orders from medical doctor (MD)-A: Aspiration precautions: (1.) Must be alert; (2.) Sit upright-all oral intake; (3.) Small bites/sips one at a time; (4.) Eat slowly; and (5.) Good oral care. The flow sheet listed treatments as: wedge cushion in w/c (wheelchair). The flow sheet was initialed by staff once on every shift from 7/1/14 thru 7/23/14, which indicated staff compliance with the physician orders as listed 1-5.

During an observation on 7/23/14, at 9:25 a.m. R22 was located in his room and there was both a high back wheelchair and a reclining geri-chair.

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No wedge cushion was evident in either chair but the ROHO cushion was present.

Review of orders dated and signed 6/18/14, by certified nurse practitioner (CNP)-A identified the following under the Cumulative Diagnosis List: Dysphagia. An interview was conducted on 7/23/14, at 10:55 a.m. with CNP-A and it was stated with a dyphagia diagnosis, the reclined position while in the geri-chair could put R22 at risk for aspiration pneumonia.

During an interview on 7/23/14, at 12:00 noon F-A verified she had been aware of R22's choking risk. She further added that staff position R22 in a reclining geri-chair due to a tendency of R22 to wiggle while seated and staff were afraid of a fall. She denied any knowledge the wedge cushion had been utilized in either the wheelchair or geri-chair.

During a telephone interview on 7/23/14, at 9:11 a.m. speech language pathologist (SLP)-A verified that R22 had not been seen nor evaluated by speech therapy (ST) for years.

An interview on 7/23/14, at 2:55 p.m. with DON-A and DON-B verified they needed to discuss with CNP-A the need to conduct a swallow evaluation due to the risk of aspiration and the need for an occupational therapy evaluation related to the use of a wedge cushion in the straight back wheelchair.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring approprate positioning during meal times. The Director of Nursing or her designee could educate staff on the policies and

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| 2 830 | Continued From page 13<br>procedures. The Director of Nursing or her designee could develop a monitoring system to ensure residents receive the appropriate care.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 830 | | |
| 2 860 | MN Rule 4658.0520 Subp. 2 F. Adequate and Proper Nursing Care; Hands-Feet<br><br>Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:<br>E. per care and attention to hands and feet. Fingernails and toenails must be kept clean and trimmed.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide personal nail care for 2 of 3 residents (R19 & R24) reviewed who were dependent upon staff for nail grooming needs.<br><br>Findings include:<br><br>Review of the minimum data set (MD) dated 7/7/14, identified that R19 had the following diagnoses: dementia and Parkinson's disease. R19 was observed on 7/21/14, at 6:44 p.m. while seated in a wheelchair in her room. It was noted that R19 had untrimmed fingernails with very sharp edges. During an observation the following afternoon on 7/22/14, at 2:35 p.m. R19's fingernails remained untrimmed with sharp edges. It was observed again on 7/23/14, at 9:51 a.m. that R19's fingernails remained untrimmed | 2 860 | | |

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with very sharp edges.

Review of the plan of care dated 10/15/12, under the heading of Nurse Aide, it specified: nail care with bath; Approaches for grooming and bathing included-extensive assist with 1 staff to assist. Review of the bath schedule identified that R19 received a bath every Thursday.

An interview was conducted on 7/24/14, at 7:19 a.m. with nursing assistant (NA)-A while observing the condition of R19's fingernails. NA-A verified that R19 had untrimmed fingernails with very sharp edges.

Review of the MDS identified that R24 had the following diagnoses: Lewy Body dementia and paralysis agitans (Parkinson's disease).

During a telephone interview on 7/21/14, at 3:59 p.m. with R24's family member (F)-A it was learned that during frequent visits she noted the following: long and dirty fingernails.

It was observed on 7/21/14, at 2:03 p.m. and on 7/23/14, at 11:35 a.m. that R24 had long, dirty fingernails that were in need of grooming. During observation on the morning of 7/24/14, at 7:14 a.m. R24 was noted to have dirty, long fingernails even though the bath had been provided on 7/22/14, two days prior.

An interview on 7/23/14, at 3:15 p.m. with director of nursing (DON)-A and DON-B verified that R24 eats a lot of finger foods which resulted in soiled fingernails frequently.

An interview was conducted on 7/24/14, at 7:14 a.m. with nursing assistant (NA)-A during observation of R24. NA-A verified that R24 had

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| 2 860 | Continued From page 15<br>dirty, long fingernails on both hands.<br><br>During an interview on 7/24/14, at 7:21 a.m. with registered nurse (RN)-C, it was also verified that R24 had dirty, long fingernails on both hands.<br><br>Review of the plan of care dated 2/15/13, under the heading of Nurse Aide, it identified: nail care with bath; Approach-grooming: dependent upon 1 assist, staff washes face/hands. Review of the bath schedule verified that R24 received a bath every Tuesday and had received a bath on Tuesday, 722/14.<br><br>A policy on nail care was requested on 7/24/14, at 10:02 a.m. and (DON)-B stated that she was not able to locate any such policy.<br><br>SUGGESTED METHOD FOR CORRECTION: The DON could insure that staff are re-inserviced as to their responsibility to provide dependent residents with assistance with nail care according to facility policy. The DON could conduct audits to ensure the care is being provided as indicated and take action as needed.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 2 860 | | |
| 2 870 | MN Rule 4658.0520 Subp. 2 H. Adequate & Proper Nursing Care-CleanClothing<br><br>Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:<br>H. Clean clothing and a neat appearance. Residents must be dressed during the day whenever possible. | 2 870 | | |

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| 2 870 | Continued From page 16<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to provide clean clothing for 1 of 3 residents (R24) reviewed who were dependent upon staff for dressing needs.<br><br>Findings include:<br><br>Review of the MDS identified that R24 had the following diagnoses: Lewy Body dementia and paralysis agitans (Parkinson's disease).<br><br>During a telephone interview on 7/21/14, at 3:59 p.m. with R24's family member (F)-A it was learned that during frequent visits she noted the following: food stained clothing.<br><br>On 7/22/14, at 1:03 p.m. R24 was observed seated in a geri-chair in the hallway by the south nursing station wearing a shirt with spilled food on the front.<br><br>An interview was conducted on 7/24/14, at 7:14 a.m. with nursing assistant (NA)-A during observation of R24. NA-A verified that R24 had a shirt with spilled liquid on it on 7/24/14 at 7:14 a.m..<br><br>During an interview on 7/24/14, at 7:21 a.m. with registered nurse (RN)-C, it was also verified that R24 had a shirt with visible spilled liquid on it. Subsequently, RN-C transported R24 to his room and changed the soiled shirt.<br><br>Review of the plan of care dated 2/15/13, identified that R24 was dependent upon staff for dressing: staff dresses/undresses upper and lower body. | 2 870 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 00682 | A. BUILDING: ______ B. WING ______ | 07/24/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKESHORE INN NURSING HOME** | **108 8TH STREET NORTHWEST WASECA, MN 56093** |

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|---|---|---|---|---|
| 2 870 | Continued From page 17<br><br>SUGGESTED METHOD OF CORRECTION: The DON could ensure that staff are re-inserviced as to their responsibility to provide dependent residents with assistance with personal care per facility policy. The DON could conduct audits to ensure the care is being provided as indicated and take action as needed.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 2 870 | | |
| 21685 | MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance<br><br>Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program.<br><br>This MN Requirement is not met as evidenced by:<br>Based on observation, interview and document review the facility failed to maintain the cleanliness of the carpet located in the front entry and down the hallway into the dining room area. This had the potential to affect all 49 residents who routinely access this multi-use area for activities, dining and family visits.<br><br>Findings include:<br><br>During observations on all days of the survey 7/21, at 2:00 p.m. 7/22, 7/23, at 9:30 a.m. and 7/24, it was noted that the carpet leading from the | 21685 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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|---|---|---|---|---|
| 21685 | Continued From page 18<br><br>front entryway into the dining room appeared heavily soiled. A soiled pathway was noted down the center of the carpet.<br><br>During an interview on 7/23/14, at 9:30 a.m. the environmental director (ED) reported the housekeeping supervisor (HS) was in charge of the carpet cleaning. During an follow-up interview on 7/23/14, at 10:25 a.m. with the HS, she verified the carpet in the entry and down the hallway into the dining area was heavily soiled. The HS stated that utility carts were routinely transported from the dietary/staff utility room door and wheeled adjacent to the main kitchen entry door, which caused the soiled path noted on the carpet. The carpet cleaning schedule was reviewed with the HS and it was noted that although the carpets had been cleaned every 5 to 7 days over the past month, the carpets remained heavily soiled.<br><br>SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could work with the director of building and grounds to develop a maintenance program to ensure floors and personal care equipment are managed/repaired to maintain a safe, clean, homelike environment. The DON or designee could educate all appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days. | 21685 | | |