#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

ID: 2V6G

#### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00682 3. NAME AND ADDRESS OF FACILITY 1. MEDICARE/MEDICAID PROVIDER NO. 4. TYPE OF ACTION: 7 (L8) (L3) LAKESHORE INN NURSING HOME (L1)245388 1. Initial 2. Recertification (L4) 108 8TH STREET NORTHWEST 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 56093 593043000 (L2)(L5) WASECA, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (1.9)05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 02 SNF/NF/Dual 06 PRTF 10 NF  $\mathbf{09/08//2014}^{(L34)}$ 14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: \_\_ (L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 12/31 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 16 HOSPICE 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: And/Or Approved Waivers Of The Following Requirements: X A. In Compliance With From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN 7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) 55 (L18) \_1. Acceptable POC 8. Patient Room Size \_\_ 9. Beds/Room Life Safety Code Not in Compliance with Program 55 (L17) 13. Total Certified Beds Requirements and/or Applied Waivers: (L12) \* Code: A 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID (L15)1861 (e) (1) or 1861 (j) (1): 55 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL Date: Gary Nederhoff, Unit Supervisor 09/22/2014 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 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) X 1. Facility is Eligible to Participate 3. Both of the Above: \_\_\_\_ 2. Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY INVOLUNTARY 12/01/1986 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L25) (141)(1.24)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44) (L27) B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS 03001 (L28) (1.31)31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE 09/17/2014

(L33)

DETERMINATION APPROVAL

(L32)



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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Division of Compliance Monitoring Minnesota Department of Health

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

# 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 245388	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 9/8/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
LA	KESHORE INN NURSING HOME		108 8TH STREET NORTHWES WASECA, MN 56093	ST

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	(Y4) Item	(Y	5) Date	(Y4)	Item	(	Y5)	Date
			Correction			Correction					Correction
ID Prefix	F0253		Completed <b>08/29/2014</b>	ID Prefix	F0279	Completed 08/29/2014		ID Prefix	F0282		Completed <b>08/29/2014</b>
	483.15(h)(2)			Reg. #	483.20(d), 483.20(k)(1)				483.20(k)(3)(ii)		<del></del>
LSC				LSC		<del>-</del>		LSC			_
		(	Correction			Correction					Correction
ID Deafis	F0200		Completed	ID Drafin	F0242	Completed		ID Deafin	F040F		Completed
ID Prefix	483.25		08/29/2014	ID Prefix	F0312 483.25(a)(3)	08/29/2014			F0465 483.70(h)		08/29/2014
LSC	465.25				465.25(a)(5)	_ 		LSC	463.70(11)		 
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Reg. # LSC				Reg. # LSC		<u> </u>		Reg. # LSC			<u> </u>
Reviewed I	By Re	eviewed	Ву	Date:	Signature of St	ırveyor:				Date:	
State Agen	cy (	GPN/KF	D	09/22/2014	_	-	0160				09/08/2014
Reviewed I	Ву R	eviewed	Ву	Date:	Signature of St	ırveyor:				Date:	
CMS RO											
Followup t	to Survey Comp		:		Check for any Unc						
	7/24/20	)14			Uncorrected Def	icielicies (Ci	vi 3-23(	or , Sent to	rule racility?	YES	NO

# Form Approved OMB NO. 0938-0390

#### **Post-Certification Revisit Report**

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(Y1) Provider / Supplier / CLIA / Identification Number 245388	(Y2) Multiple Con A. Building B. Wing	° 01 - MAIN BUILDING 01		
Name of Facility			Street Address, City, State, Zip Code	
LAKESHORE INN NURSING HOME			108 8TH STREET NORTHWES WASECA MN 56093	ST

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(Y4) Item		(Y5) Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
ID Prefix		Correction Completed 08/29/2014	ID Prefix		C	Correction Completed 9/08/2014		ID Prefix			Correction Completed 08/29/2014
Reg. #	NFPA 101			NFPA 101				Reg. #	NFPA 101		
LSC	K0050		LSC	K0054				LSC	K0062		<u> </u>
		Correction			C	Correction					Correction
ID Prefix		Completed <b>08/29/2014</b>	ID Prefix		C	Completed		ID Prefix			Completed
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J	K0144		LSC					LSC			 
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Reg. # LSC			Reg. # LSC					Reg. # LSC			<u> </u>
Reviewed I	Ву R	eviewed By	Date:	Signature	e of Surv	eyor:				Date:	
State Agen	cy ]	PS/KFD	09/22/20	)14		25	822				09/12/2014
Reviewed I	By R	eviewed By	Date:	Signatur	e of Surv	eyor:				Date:	
CMS RO											
Followup t	to Survey Comp 7/23/2			Check for an Uncorrect					Summary of the Facility?		NO

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

#### MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2V6G PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00682 1. MEDICARE/MEDICAID PROVIDER NO. 3. NAME AND ADDRESS OF FACILITY 4. TYPE OF ACTION: 2 (L8) (L3) LAKESHORE INN NURSING HOME (L1)245388 1. Initial 2. Recertification (L4) 108 8TH STREET NORTHWEST 2.STATE VENDOR OR MEDICAID NO. 4. CHOW 3. Termination (L6) 56093 593043000 (L2)(L5) WASECA, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 (L7)8. Full Survey After Complaint (1.9)05 HHA 13 PTIP 01 Hospital 09 ESRD 22 CLIA 6. DATE OF SURVEY 02 SNF/NF/Dual 06 PRTF 10 NF 07/24/2014 (L34)14 CORF FISCAL YEAR ENDING DATE: (L35)8. ACCREDITATION STATUS: 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC (L10) 12 RHC 12/31 0 Unaccredited 1 TJC 04 SNF 08 OPT/SP 16 HOSPICE 2 AOA 3 Other 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: And/Or Approved Waivers Of The Following Requirements: A. In Compliance With From (a): Program Requirements 2. Technical Personnel 6. Scope of Services Limit To (b): Compliance Based On: 3. 24 Hour RN 7. Medical Director 12. Total Facility Beds 4. 7-Day RN (Rural SNF) 55 (L18) \_1. Acceptable POC 8. Patient Room Size \_\_ 9. Beds/Room Life Safety Code X B. Not in Compliance with Program 55 (L17) 13. Total Certified Beds Requirements and/or Applied Waivers: (L12)\* Code: **B**\* 14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 18 SNF 18/19 SNF 19 SNF ICF IID 1861 (e) (1) or 1861 (j) (1): (L15)55 (L37)(L38)(L39)(L42)(L43)16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 17. SURVEYOR SIGNATURE 18. STATE SURVEY AGENCY APPROVAL Date: 09/09/2014 Connie Brady, HFE NE II Kamala Fiske-Downing, Enforcement Specialist 09/15/2014 (L19)(L20) PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY 19. DETERMINATION OF ELIGIBILITY 20. COMPLIANCE WITH CIVIL 1. Statement of Financial Solvency (HCFA-2572) RIGHTS ACT: Ownership/Control Interest Disclosure Stmt (HCFA-1513) Facility is Eligible to Participate 3. Both of the Above: Facility is not Eligible (L21) 22. ORIGINAL DATE 23. LTC AGREEMENT 24. LTC AGREEMENT 26. TERMINATION ACTION: (L30) 00 OF PARTICIPATION BEGINNING DATE ENDING DATE VOLUNTARY INVOLUNTARY 12/01/1986 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement (L25) (141)(L24)03-Risk of Involuntary Termination 25. LTC EXTENSION DATE: 27. ALTERNATIVE SANCTIONS 04-Other Reason for Withdrawal 07-Provider Status Change A. Suspension of Admissions: 00-Active (L44) (L27) B. Rescind Suspension Date: (L45)28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 30. REMARKS

(1.31)

(L33)

DETERMINATION APPROVAL

03001

32. DETERMINATION OF APPROVAL DATE

(L28)

(L32)

31. RO RECEIPT OF CMS-1539



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 <u>only a suggestion</u> 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

Kumalu Fiske Downing

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

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

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(X3) DATI	(X3) DATE SURVEY COMPLETED	
	245388				07/	07/24/2014	
	PROVIDER OR SUPPLIER ORE INN NURSING F	IOME		STREET ADDRESS, CITY, STATE, ZIP CODE 108 8TH STREET NORTHWEST WASECA, MN 56093			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 000	INITIAL COMMEN	rs	FO	00			
	as your allegation of Department's accept	of correction (POC) will serve of compliance upon the otance. Your signature at the page of the GMS-2567 form will tion of compliance.					
F 253	revisit of your facilit validate that substa regulations has bee your verification. 483.15(h)(2) HOUS	acceptable POC an on-site y may be conducted to untial compliance with the en attained in accordance with	F 2	53 R24's lap buddy was replaced frayed lap buddies have beer	llA .b	8/29	
SS=D	MAINTENANCE SI  The facility must pr maintenance service	ERVICES ovide housekeeping and ses necessary to maintain a nd comfortable interior.		discarded. New lap buddies vordered. All nursing staff have educated (via meeting and ponotes) to monitor equipment any items not in good repair.	vere e been osted	, , ,	
	by: Based on observa failed to ensure a p maintained in good cleaned for 1 of 1 r	NT is not met as evidenced tion and interview the facility positioning device was I repair so it could be properly esident (R24) who had a lap of foam padding evident on all evice.	9/3// GPN	DON or designee will monitor residents with lap buddies to condition of lap buddy is in go We will monitor the lap buddie for 6 months. The results will reported to the QI committee quarterly meetings.	ensure ood repair. es monthly be		
·	had a positioning d between the arms poor repair. R24 had arms and hands of position the hands padding located ins	7/24/14, at 7:14 a.m. that R24 levice/lap buddy placed of the wheelchair which was in ad the ability to place both in top of the lap buddy to and/or arms. The foam side the vinyl covering was		TITLE		(X6) DATE	

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.

Event ID: 2V6G11

RECENTED

If continuation sheet Page 1 of 19

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

CENTER	13 I OH WILDIOANE	A WEDIONID CETTOLO				WO DATE	CHOVEA
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION	N .	(X3) DATE SURVEY COMPLETED	
	•	245388	B. WING			07/2	4/2014
NAME OF F	PROVIDER OR SUPPLIER		<u>'                                      </u>	STREET ADDRESS,	CITY, STATE, ZIP CODE		
LAVEOU	ORE INN NURSING H	IOME		108 8TH STREET			·
LAKESH	OHE INN NURSING H	TOWE		WASECA, MN		-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD FERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 253	corners of this posion 7/24/14, at 7:14 (NA)-A during the ocondition of the lap It was observed on independently conseated in the wheel buddy. During ano 12:30 p.m. R24 was dining room and at food, was noted tuchair.  Interview on 7/23/1 nursing (DON)-A areats a lot of finger for 7/24/14, at 7:21 a.m. (RN)-C, it was verif device utilized by Redding evident on buddy. RN-C was upside down to che surface was in goo sides of the device. The foam padding vinyl covering. RN equipment could no sanitized and was it his lap buddy was and re-applied sevethe day as necessar 483.20(d), 483.20(COMPREHENSIVE	and bottom edges of all four tioning device. An interview a.m. with nursing assistant observation of R24 verified the buddy.  7/21/14, at 5:15 p.m. that R24 sumed the evening meal while lichair with the attached lap ther observation on 7/22/14, at a seated in a geri-chair in the towel, which contained spilled oked into the left side of the  4, at 3:15 p.m. with director of and DON-B verified that R24 foods. During an interview on an with registered nurse fied the lap buddy positioning all four edges of the lap noted to flip the lap buddy eck whether the opposite of repair and noted that both had exposed foam padding, was protruding outside the C confirmed the resident care of be cleaned and properly in poor repair. It was verified removed from the wheelchair eral times by staff throughout ary for R24.  k)(1) DEVELOP E CARE PLANS		279			
	A facility must use to develop, review	the results of the assessment and revise the resident's		E-W-ID AAAAA	V	otion sheet	t Page 2 of 19
EODM ONE 36	567/02-99) Previous Versions	s Obsolete Event ID: 2V6G1	1	Facility ID: 00682	ii continui	21101121166	11 aye 2 01 19

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00682

RECEIVED SEP 02 2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MUI A. BUILE		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ļ		245388	B. WING			07/2	24/2014
	PROVIDER OR SUPPLIER ORE INN NURSING H	IOME	L.,	1	TREET ADDRESS, CITY, STATE, ZIP CODE 08 8TH STREET NORTHWEST VASECA, MN 56093		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFIGIENCY)	BE	(X5) COMPLETION DATE
F 279	plan for each reside objectives and time medical, nursing, a needs that are identification assessment.  The care plan must to be furnished to a highest practicable psychosocial well-b §483.25; and any sidue to the resident §483.10, including under §483.10(b)(4)  This REQUIREMENT Based on interview facility failed to device with the hospice.	n of care.  Evelop a comprehensive care ent that includes measurable stables to meet a resident's and mental and psychosocial tified in the comprehensive  It describe the services that are attain or maintain the resident's physical, mental, and leing as required under ervices that would otherwise \$483.25 but are not provided as exercise of rights under the right to refuse treatment of the right to refuse treatment of the resident as evidenced and document review the elop a coordinated plan of the agency for 1 of 1 resident on had hospice services	Fí	279		staff re and were  nitor e and the	8/29
	Findings include:						
	being admitted to the hursing progressing was admitted to	ty face sheet identified R62 as he facility on 4/4/14. Review of ss notes identified that R62 o the hospice program on osis of cachexia (wasting					
	Review of R62's pl	an of care dated 7/2/14, had received end of life care					

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. Facility ID: 00682

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Munestoa Department of Health Marshall

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245388	B. WING		07/	24/2014
	PROVIDER OR SUPPLIER ORE INN NURSING H	IOME		STREET ADDRESS, CITY, STATE, ZIP CODE 108 8TH STREET NORTHWEST WASECA, MN 56093		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE
F 279 F 282 SS=D	from hospice. The in the medical recording interview on director of nursing agency had not proof care located in the been a plan of care facility and the hospitative and the two er 483.20(k)(3)(ii) SEI PERSONS/PER Comments to a provided the provided to the most be provi	hospice plan of care located rd was left blank.  17/24, at 10:43 a.m. the (DON) verified the hospice wided a care plan and the plan me medical record had not yet everified there should have developed between the pice agency to coordinate care attities.		R24's Care Plan has been upd Approached added: monitor fo change shirt throughout the da monitor nails for cleanliness d cares, wash hands/face after e meal/snack, provide clothing p with meals and as needed, che wheelchair daily for cleanliness	need to y if soiled aily with very otector ck and	8/29
	by: Based on observa review the facility fa services according of 3 residents (R19 dependent upon st failed to properly previewed who was Findings include: Review of the mini 7/7/14, identified th diagnoses: demen	NT is not met as evidenced tion, interview and document ailed to provide grooming to the written plan of care for 2 & R24) reviewed who were aff for grooming needs and osition 1 of 1 resident (R22) at risk for aspiration.  mum data set (MD) dated nat R19 had the following tia and Parkinson's disease.  of care for R19, dated e heading of Nurse Aide,		have housekeeping clean as n R19's care plan has been updatrim nails with bath as needed monitor nails for sharp edges. R22's care plan was reviewed evaluated wheelchair positioni 7/23/14. Resident was transfer an upright wheelchair with a w cushion to assure proper posit throughout the day as well as meal times. Therapy provided to staff and family on proper v positioning. This wheelchair ha effective and is now his primar Speech Therapy evaluated residuring supper on 7/23/14.	ted to and Therapy of on red into edge oning during the lending th	

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245388	B. WING			07/2	24/2014
	PROVIDER OR SUPPLIER ORE INN NURSING H	IOME		10	TREET ADDRESS, CITY, STATE, ZIP CODE 08 8TH STREET NORTHWEST VASECA, MN 56093		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE !	(X5) COMPLETION DATE
F 282	specified: nail care for grooming and b assist with 1 staff to schedule identified every Thursday.  R19 was observed seated in a wheelch that R19 had untring sharp edges. During afternoon on 7/22/1 fingernails remaine edges. It was obseam, that R19's fing with very sharp edges. An interview was caum, with nursing a observing the cond NA-A verified that F with very sharp edge been followed as well as with the season of the plan under the heading care with bath. The dependent upon 1 face/hands, brusheand does peri-care assist, staff dressehody. Review of the staff care with Review of the staff dressehody. Review of the staff dressehody. Review of the staff care with Review of the staff dressehody. Review of the staff care with Review of the staff dressehody.	with bath; and approaches athing included-extensive assist. Review of the bath that R19 received a bath on 7/21/14, at 6:44 p.m. while nair in her room. It was noted amed fingernails with very an an observation the following 4, at 2:35 p.m. R19's duntrimmed with sharp erved again on 7/23/14, at 9:51 pernalls remained untrimmed pers.  Onducted on 7/24/14, at 7:19 ssistant (NA)-A while ition of R19's fingernails. R19 had untrimmed fingernails ges. The plan of care had not written.  The plan of care had not written.	F 2	282	They noted congested cough well the meal which Speech Therapist felt was not swallowing related. Speech Therapist made no changes to cur diet or plan of care. A training memo has been posted in employee dining room and on the wings for all employees is every department's responsibility to ensure proper grooming of residents. Any employee that sees resident that is not properly groomed should notify the immediately. Nursing staff provided review (via a training memo posted in the employee din room and on the wings) of proper positioning techniques a precautions to take when feeding a resident who is at aspiration. DON or designee will monitor 10% of the residents for proper grooming, wheelchair positioning, cushion placement, and proper positioning during meals. The done weekly for 4 weeks, semi-monthly for 2 month monthly for 3 months. The results will be reported discussed at the QI meetings.	the the s that it ure s a e nurse d with ing and risk for	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	COL	COMPLETED	
	245388	B. WING			/24/2014	
NAME OF PROVIDER OR SUPPLIAKESHORE INN NURSI			STREET ADDRESS, CITY, STATE, Z 108 8TH STREET NORTHWEST WASECA, MN 56093			
PREFIX (EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
p.m. with R24' learned that difollowing: long clothing, uncle soiled wheelch lit was observed 7/23/14, at 11: fingernails that observation or a.m. R24 was even though the 7/22/14, two difference and partially under the p.m. R24 was room and a to was noted tuction and partially under the station wearing front and was stained a reduction of nursing (DC) that R24 eats in soiled finge the p.m. with nurse observation or dirty, long fing shirt had visib the point of the p.m. R24 was room and a town and the p.m. R24 was room and a town and partially under the p.m. R24 was room and a town and p.m. R24 was room and a town a	none interview on 7/21/14, at 3:59 is family member (F)-A it was string frequent visits she noted the land dirty fingernalis, food stained an skin and at times seated in a air.  I don 7/21/14, at 2:03 p.m. and on 35 a.m. that R24 had long, dirty were in need of grooming. During the morning of 7/24/14, at 7:14 noted to have dirty, long fingernalists bath had been provided on any prior.  I observation on 7/22/14, at 12:30 seated in a geri-chair in the dining wel, which contained spilled food, ked into the left side of the chair indemeath R24. On 7/22/14, at was observed seated in a e hallway by the south nursing g a shirt with spilled food on the seated on an incontinence pad, color.  In 7/23/14, at 3:15 p.m. with directors of the color of finger foods which resulted	r	282			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
-		245388	B. WING			07/2	24/2014
	PROVIDER OR SUPPLIER ORE INN NURSING H	OME		10	REET ADDRESS, CITY, STATE, ZIP CODE 8 BTH STREET NORTHWEST ASECA, MN 56093		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	the shirt had stained transported R24 int shirt.  R22 had diagnoses set (MDS) as noted (L) [left] above the lidabetes.  The plan of care dathe following was not (1) Problem: Self C decreased mobility; and diabetes. Approved Aide-Eating: Independent of the diabetes of (L) above the memory; depression (4/25/14)wedge prevent resident from (3) Problem dated alteration. Approved to dysphagia.	fingernails on both hands and diquid. Subsequently, RN-C o his room and changed the listed on the minimum data depression; Hx [history] of knee amputation (AKA) and sted 5/6/14, was reviewed and oted: are Deficit: related to Hx of (L) AKA; depression; roach dated 4/30/13, Nurse andent after staff provides tray 4/30/14: Potential related to impaired mobility; knee amputation; impaired n; diabetes. Approach: dated cushion in wheelchair to som sliding forward; and 1/28/14: Potential for nutrition the Assisted feeding table, a trained feeding assistant due	F2	282			
	part of the July 201 the following orders Aspiration precaution upright-all oral intal a time; (4.) Eat slo The flow sheet liste cushion in w/c (who initialed by staff on thru 7/23/14, which	sheet, which was identified as 4 plan of care plan, identified as from medical doctor (MD)-A: ons: (1.) Must be alert; (2.) Sit ke; (3.) Small bites/sips one at wly; and (5.) Good oral care. It is determined that the same was been every shift from 7/1/14 indicated staff compliance orders as listed 1-5.		-		-	

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<u> </u>	13 I ON WEDIOAITE	C (MEDIO/NO GENTAGE)			(X3) DATE SURVEY		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		PLETED
		245388	B. WING			07/2	24/2014
	PROVIDER OR SUPPLIER ORE INN NURSING H	IOME		10	TREET ADDRESS, CITY, STATE, ZIP CODE D8 8TH STREET NORTHWEST /ASECA, MN 56093	·	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE !	(X5) COMPLETION DATE
F 282	During an observate the dining room it was seated in a geri-chair was rediffed degree angle. At 5 cough repeatedly a loose sounding philoswallowed. At 5:20 walked over to R22 forward by placing back. It was observed in the geriside after the applicate 5:30 p.m. R22 was seated in the geriside after the applicate for walked out the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the seated in the geriside after the applicate for the geriside after	ion on 7/21/14, at 5:15 p.m. in vas noted that R22 was air, in a reclined position. The ned at approximately 50 :19 p.m. R22 was noted to and cleared his airway after egm was expectorated and p.m. nursing assistant (NA)-C and attempted to prop him several pillows behind his ved that R22 remained chair but leaned to the left cation of the additional pillows. vas observed to consume a and coughed repeatedly in an	F:	282			
	On 7/22/14, at 8:10 eating breakfast in noted to be recline approximately a 50 breakfast, R22 was Trained medication until the airway was immediate area.  During an observa R22 was seated in the noon meal. R2 12:26 p.m. which consider that R2 without difficulty. A cold broccoli. R22 republications and the sead of broccoli. R22 republications are seasons as a season was noted that R2 without difficulty. A cold broccoli. R22 republications are seasons as a season was noted that R2 without difficulty. A cold broccoli. R22 republications are season was noted that R2 republications are season was noted that R2 without difficulty. A cold broccoli. R22 republications are season was noted that R2 republications are season was noted that R2 republications.	a.m. R22 was observed while the dining room and was again d in the geri chair at degrees angle. While eating a noted to repeatedly cough. It is added to repeatedly cough. It is a cleared, and then left the stion on 7/22/14, at 12:20 p.m. The reclined geri-chair during 22 received his food tray at consisted of chicken, crinkle cut broccoli salad and buttered in was cut up by NA-C and it 2 was able to feed himself at 12:33 p.m. R22 consumed a which contained large pieces epeatedly coughed. At 12:48 sip of water, coughed this airway. R22 continued to					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING		E SURVEY IPLETED
		245388	B. WING	B. WING		24/2014
	PROVIDER OR SUPPLIER ORE INN NURSING H	OME		STREET ADDRESS, CITY, STATE, ZIP CODE 108 8TH STREET NORTHWEST WASECA, MN 56093		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ULD BE	(X5) COMPLETION DATE
F 309 SS=D	intermittently cough noted in his throat.  An observation on a conducted while R2 geri-chair in the dinagain reclined to apangle. The meal of syrup, sausage link R22 fed himself and food items. At 8:19 holding a fork which on it. R22 was identified the cleared his aimappeared to be could water to R22 be creach due to being An interview on 7/2 and DON-B verified not been followed a wedge cushion in for positioning in an 483.25 PROVIDE OF HIGHEST WELL B.  Each resident must provide the necess or maintain the highmental, and psychological.	7/23/14, at 8:00 a.m. was 22 was seated in a reclined ing room. The gerl-chair was proximately a 50 degree posisted of french toast with s, juice, water and coffee. It is a many constant of the cut up his a.m. R22 was observed in had an entire sausage link at tified to repeatedly cough and way. At 8:34 a.m. R22 ghing. NA-D handed a glass cause his water was out of his in a reclined position.  3/14, at 2:55 p.m. with DON-A I verified the plan of care had as written for R22 related to a is wheel chair and the need a upright wheel chair.		309		
	bv:	NT is not met as evidenced tion, interview and document				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245388	B. WING			07/2	24/2014
	PROVIDER OR SUPPLIER ORE INN NURSING H	HOME		10	TREET ADDRESS, CITY, STATE, ZIP CODE 08 8TH STREET NORTHWEST VASECA, MN 56093		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	review the facility factoring during (R22) reviewed where Findings include: R22 had diagnoses set (MDS) as noted (L) [left] above the depression; and diagnoses set (material and particular and particul	ailed to provide proper meal time for 1 of 1 resident o was at risk for aspiration.  Is listed on the minimum data did did depression; Hx [history] of knee amputation (AKA); abetes.  Ition on 7/21/14, at 5:15 p.m. in was noted that R22 was seated reclined position. The ined at approximately 50 sing p.m. R22 was noted to and cleared his airway after legm was expectorated and p.m. nursing assistant (NA)-C and attempted to prop him several pillows behind his rived that R22 remained chair but leaned to the left cation of the additional pillows. Was observed to consume a seand coughed repeatedly in an		309	R22's care plan was reviewed. The valuated wheelchair positioning 7/23/14. Resident was transferred an upright wheelchair with a wed cushion to assure proper position throughout the day as well as during times. Therapy provided instruction to staff and family on wheelchair positioning. This wheelchair positioning. This wheelchair positioning. This wheelchair positioning. Therapy evaluated resident during supper 7/23/14. They noted congested of well after the meal which Speech Therapist felt was not swallowing related. Speech Therapist made changes to current diet or plan of Nursing staff provided with review training memo posted in the empty dining room and on the wings) of positioning techniques and precest to take when feeding a resident of a trisk for aspiration.  DON or designee will monitor 10 the residents for proper grooming wheelchair positioning, cushion placement, and proper positioning during meals. This will be done of the total proper to the total proper during meals. This will be done of the total proper during meals. This will be done of the total proper during meals. This will be done of the total proper during meals. This will be done of the total proper during meals. This will be reported and discussed a meetings.	on d into ge aing proper elchair s on cough l no f care. w (via a aloyee proper autions who is % of g, ag weekly months, results	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245388	B. WING	G	٠	07/	24/2014
	PROVIDER OR SUPPLIER ORE INN NURSING H	IOME		STREET ADDRESS, CITY, STATE, ZIP CO 108 BTH STREET NORTHWEST WASECA, MN 56093	DE		
· (X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE ACTION S	HOULD B	BE ATE	(X5) COMPLETION DATE
F 309	12:26 p.m. which consider the continued to intermal to be sugarior to the displayment of the continued to intermal to be sugarior to the meal. At 12:48 coughed repeatedly continued to intermal loose phlegm noted. An observation on a conducted while Riggeri-chair in the dinfeeding table with swas again reclined angle. The meal construction on the conducted himself and food items. At 8:19 holding a fork which on it. R22 was identiced the cleared his aim appeared to be couphlegm so NA-D has	2 received his food tray at consisted of chicken, crinkle cut broccoli salad and buttered in was cut up by NA-C and it was able to feed himself to 12:33 p.m. R22 consumed a which contained large pieces peatedly coughed throughout p.m. R22 drank a sip of water, and cleared his airway. R22 littently cough, with audible in his throat.  7/23/14, at 8:00 a.m. was 22 was seated in a reclined ing room at the assisted taff present. The geri-chair to approximately a 50 degree onsisted of french toast with s, juice, water and coffee, d no staff offered to cut up his a.m. R22 was observed in had an entire sausage link intified to repeatedly cough and way. At 8:34 a.m. R22 ghing and not clearing the unded a glass of water to R22 was not within reach due to	F	309			
	discharge summary identified that R22 " determine if there w status". "Res. [resided self independed Occupation Therap Identified the follow	pational therapy (OT)  / dated 2/27/14 thru 3/12/14,  fwas seen again this week to  // dated 2/27/14 thru 3/12/14,  fwas seen again this week to  // dated 2/27/14 thru 3/12/14,  fwas seen again this week to  // dated 10/14/14  ing under the Summary  // reported Pt. [patient]sliding					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		245388	B. WING	)		07/	24/2014
	PROVIDER OR SUPPLIER ORE INN NURSING H	OME		STREET ADDRESS, CITY, STATE, ZIP 108 8TH STREET NORTHWEST WASECA, MN 56093	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD IE APPROPR	BE	(X5) COMPLETION DATE
F 309	set up to prevent sl Short Term Goal wa up to prevent sliding Care Goal was: pt. positioning in w/c. w/c. Another review thru 11/12/13 verifice times] for w/c positi in w/c with no more was sliding forward w/c cushion which   "no more concerns  R22 was observed being seated in an positioned in the ge R22 was seated on covered cushion th prevent skin breake dysum (a thin pad t cushion from sliding the cushion. Althou ROHO cushion from wheelchair, a cover ROHO cushion and prevent R22 from s wheelchair.  During an interview NA-A, indicated the noon meal, R22 wa wheelchair and not member (F)-A com NA-A further added around the facility the high back whee than the geri chair.	elchair] and needs new w/c iding out of wheelchair. The as: Pt. will tolerate new w/c set g out of w/c. The Long Term will demonstrate upright Pt./Family Goal: Upright in w of OT notes dated 11/1/13 and that R22 "was seen 3x [3 oning". "Pt now sitting upright concerns from nursing". "Pt in w/c". "Pt was given new promotes upright position". with sliding forward".  on 7/23/14, at 11:30 a.m. as upright wheelchair and not wird-chair as noted previously. a ROHO (a nylon type fabric at distributes weight evenly to down) cushion that had a hat would prevent the ROHO g forward) located underneath ugh the dysum prevented the n sliding forward in the ring was absent from the nylon I the slippery surface did not	F	309			

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OLIVILI	TO TOTT WILD TO THE	WIND OF THE					
	OF DEFICIENCIES OF CORRECTION	(X!) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245388	B. WING			. 07/2	24/2014
	PROVIDER OR SUPPLIER ORE INN NURSING H	HOME		1	STREET ADDRESS, CITY, STATE, ZIP CODE 08 8TH STREET NORTHWEST NASECA, MN 56093		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	maybe because it's	tge 12 -A stated, "I don't know, easier for him to relax?" essment (CAA's) for R22 dated	F:	309			
	4/25/14 was review documentation ider wheelchair to preve forward. The # 12-dated 4/29/14 iden	red and the #11- Fall ntified: wedge cushion in ent resident from sliding Nutrition CAA documentation tified: proper positioning in r dining due todysphagia					
	the following was n (1) Problem: Self C decreased mobility [left] above the kne diabetes. Approac Aide-Eating: Indeposet up. (2) Problem dated trauma-falls injury of Hx of (L) above the memory; depressio (4/25/14)wedge prevent resident from (3) Problem dated alteration. Approach	care Deficit: related to ; depression; Hx [history] of (L) se amputation; depression; and h dated 4/30/13 Nurse endent after staff provides tray					
	part of the July 201 the following order Aspiration precauti upright-all oral inta a time; (4.) Eat slo The flow sheet list	sheet, which was identified as 14 plan of care plan, identified rs from medical doctor (MD)-A: ions: (1.) Must be alert; (2.) Sit ke; (3.) Small bites/sips one at owly; and (5.) Good oral care. ed treatments as: wedge eelchair). The flow sheet was					

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Facility ID: 00682

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CLIVIL.	TO TOTALISTONE	A MEDIOMO OFFICE					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	ULTIPLE CONSTRUCTION DING			E SURVEY PLETED
		245388	B. WING	3		07/	24/2014
	PROVIDER OR SUPPLIER ORE INN NURSING H	IOME		STREET ADDRESS, CITY, STATE, ZIP O 108 8TH STREET NORTHWEST WASECA, MN 56093	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECTIVE ACTION	V SHOULD	BE	(X5) COMPLETION DATE
F 309	initialed by staff one thru 7/23/14, which with the physician of During an observat R22 was located in a high back wheeld No wedge cushion the ROHO cushion Review of orders decriffied nurse pracefollowing under the Dysphagia. An interview of the Dysphagia. An interview of the Dysphagia. An interview of the Dysphagia of the Dysp	ce on every shift from 7/1/14 indicated staff compliance orders as listed 1-5.  ion on 7/23/14, at 9:25 a.m. his room and there was both hair and a reclining geri-chair. was evident in either chair but was present.  ated and signed 6/18/14, by titioner (CNP)-A identified the Cumulative Diagnosis List: erview was conducted on m. with CNP-A and it was gia diagnosis, the reclined e geri-chair could put R22 at neumonia.  on 7/23/14, at 12:00 noon F-A en aware of R22's choking ided that staff position R22 in ir due to a tendency of R22 to a land staff were afraid of a fall. by building the wedge cushion either the wheelchair or interview on 7/23/14, at 9:11 age pathologist (SLP)-A ad not been seen nor	F3	309			
	An interview on 7/2 and DON-B verified CNP-A the need to due to the risk of as occupational therap	th therapy (ST) for years.  3/14, at 2:55 p.m. with DON-A I they needed to discuss with conduct a swallow evaluation spiration and the need for an by evaluation related to the use In the straight back					

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Manestoa Department of Health Marshall

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED	
		245388	B. WING		07/2	4/2014
	PROVIDER OR SUPPLIER	HOME	1	TREET ADDRESS, CITY, STATE, ZIP CODE 08 8TH STREET NORTHWEST VASECA, MN 56093		
(X4) ID PREFIX TAG	(FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
	the plan of care hat for R22 related to a chair and/or the new wheel chair.  483.25(a)(3) ADL (DEPENDENT RESTANCE A resident who is used to be a considerable of the maintain good nutrand oral hygiene.  This REQUIREMED by:  Based on observer review the facility for a care and grooming R24) reviewed who for nail grooming reds.  Findings include:  Review of the min 7/7/14, identified to diagnoses: demer R19 was observed seated in a wheeled that R19 had untrasharp edges. Durafternoon on 7/22 fingernalis remain edges. It was observed that R19 had untrasharp edges.	A and DON-B further verified d not been followed as written a wedge cushion in his wheel and for positioning in an upright care provided for provided for the necessary services to dition, grooming, and personal for a provided personal nailed to provide personal nailed for 2 of 3 residents (R19 & owere dependent upon staff needs and personal hygiene for 2 of 3 residents (R19 & owere dependent upon staff needs and personal hygiene for 121/14, at 6:44 p.m. while that R19 had the following that and Parkinson's disease. If on 7/21/14, at 6:44 p.m. while of the provided formed fingernails with very ing an observation the following for a construction of		R24's Care Plan has been updat Approached added: monitor for rehange shirt throughout the day soiled, monitor nails for cleanline with cares, wash hands/face aft meal/snack, provide clothing prowith meals and as needed, check wheelchair daily for cleanliness a have housekeeping clean as needed at monitor nails for sharp edges. A training memo has been update trim nails with bath as needed at monitor nails for sharp edges. A training memo has been posted employee dining room and on the wings for all employees that it is department's responsibility to enproper grooming of residents. At employee that sees a resident the not properly groomed should not properly groomed should not not properly groomed should not properly groomed	need to if ses daily er every otector k and eded. ed to ad in the ne every sure ny nat is tify the 0% of g, mg weekly months, results	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245388	B. WING			07/	24/2014
	PROVIDER OR SUPPLIER ORE INN NURSING H	ЮМЕ	·	1	TREET ADDRESS, CITY, STATE, ZIP CODE 08 8TH STREET NORTHWEST VASECA, MN 56093	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	XTEMENT OF DEFICIENCIES Y MUST BE PRÉCEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 312			F	312			
	the heading of Nurswith bath; Approactincluded-extensive	of care dated 10/15/12, under se Aide, it specified: nail care shes for grooming and bathing assist with 1 staff to assist. schedule identified that R19 ery Thursday.					
	a.m. with nursing a observing the cond	onducted on 7/24/14, at 7:19 ssistant (NA)-A while lition of R19's fingernails. R19 had untrimmed fingernails ges.	-		·		,
	following diagnose:	didentified that R24 had the s: Lewy Body dementia and Parkinson's disease).					
	p.m. with R24's fan learned that during following: long and	interview on 7/21/14, at 3:59 nily member (F)-A it was frequent visits she noted the dirty fingernalls, food stained kin and at times seated in a					
	7/23/14, at 11:35 a fingernails that wer observation on the a.m. R24 was note	17/21/14, at 2:03 p.m. and on m.m. that R24 had long, dirty re in need of grooming. During morning of 7/24/14, at 7:14 d to have dirty, long fingernalls ath had been provided on prior.					
	p.m. R24 was seat room and a towel, was noted tucked and partially under	servation on 7/22/14, at 12:30 ted in a geri-chair in the dining which contained spilled food, into the left side of the chair neath R24. On 7/22/14, at sobserved seated in a					

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<u> </u>	TO LOU MEDICALL	A MEDICAID SERVICES			CIVID	140. 0930-0331
	OF DEFICIENCIES OF GORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3	3) DATE SURVEY COMPLETED
		245388	B. WING_			07/24/2014
	Provider or Supplier I <b>ore inn Nursing</b> H	OME		STREET ADDRESS, CITY, STATE, ZIP COD 108 8TH STREET NORTHWEST WASECA, MN 56093	Ξ · · · · · ·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	
F 312	station wearing a shartont and seated on stained in a reddish. An interview on 7/20 of nursing (DON)-A eats a lot of finger for fingernails frequently an interview was coal a.m. with nursing as observation of R24. dirty, long fingernails shirt had spilled liqued During an interview registered nurse (R1 R24 had dirty, long the shirt had visible Subsequently, RN-Cand changed the soat Review of the plant of the heading of Nurswith bath; Approach 1 assist, staff washes shaves, combs hair dependent upon 1 adresses/undresses Review of the bath services of the bath services and	way by the south nursing nirt with spilled food on the a visible incontinence pad color.  3/14, at 3:15 p.m. with director and DON-B verified that R24 bods which resulted in soiled y.  Inducted on 7/24/14, at 7:14 sistant (NA)-A during NA-A verified that R24 had son both hands and R24's id on it.  In 7/24/14, at 7:21 a.m. with N)-C, it was also verified that ringernails on both hands and spilled liquid on it.  It transported R24 to his room illed shirt.  In care dated 2/15/13, under the Aide, it identified: nail care and component and compone	F 3*	12		
F 465	on 7/24/14, at 10:02	and grooming was requested a.m. and (DON)-B stated e to locate any such policy.	F 46	65		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUİLC		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245388	B. WING			07/2	24/2014
NAME OF	PROVIDER OR SUPPLIER	<u></u>			TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKESH	IORE INN NURSING H	KOME			08 8TH STREET NORTHWEST VASECA, MN 56093		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	}B∈	(X5) COMPLETION DATE
F 465 SS=C	SAFE/FUNCTION/E ENVIRON  The facility must present sanitary, and comforces from the facility from the	accorded a safe, functional, portable environment for I the public.  No is not met as evidenced ation, interview and document ailed to maintain the carpet located in the front entry way into the dining room area, tial to affect all 49 residents as this multi-use area for and family visits.  The son all days of the survey 7/22, 7/23, at 9:30 a.m. and that the carpet leading from the the dining room appeared oiled pathway was noted down		165	F465 The carpet was cleaned with a ne cleaner and new method. So far the method is working well. If that stop being the case, we will look at oth solutions. Housekeeping will put if the communication book for anybreport any soiled areas. Housekee will clean any soiled carpet that is reported or noted by housekeeping Housekeeping director, or design monitor high traffic areas of carpe for a month, weekly for 3 months monthly for 2 months. The results discussed at the QI meetings.	he new ps er notes in ody to eping g staff. ee will and	8/29

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTION ING	(EX)	(X3) DATE SURVEY COMPLETED	
		245388	B. WING			07/	/24/2014
ļ	PROVIDER OR SUPPLIER ORE INN NURSING H	IOME		STREET ADDRESS, CITY, STATE, ZIP CODE 108 8TH STREET NORTHWEST WASECA, MN 56093			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORR PREFIX (EACH CORRECTIVE ACTION SI TAG CROSS-REFERENCED TO THE AP DEFICIENCY)			.D BE	(X5) COMPLETION DATE
F 465	reviewed with the H	ge 18 IS and it was noted that s had been cleaned every 5 to t month, the carpets remained	F4	65	,		
					·		

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Manestoa Department of Health Marchall

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 245388 B. WING 07/23/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 108 9TH STREET NORTHWEST LAKESHORE INN NURSING HOME WASECA, MN 56093 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **PREFIX** PRÉFIX TAG TAG DEFICIENCY) INITIAL COMMENTS K 000 K 000 FIRE SAFETY POC 0K

18 9-9-14 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. 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. 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/Medicald 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. PLEASE RETURN THE PLAN OF 8 2014 CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES** ( K-TAGS) TO: MN DEPT. OF PUBLIC SAFETY ATE FIRE MARSHAL DIVISION Health Care Fire Inspections

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

State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or

TITLE

MENZSTEATER

(X6) DATE

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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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		24538B	B. WING_		07/23/2014	
	PROVIDER OR SUPPLIER ORE INN NURSING H	IOME		STREET ADDRESS, CITY, STATE, ZIP CODE 108 STH STREET NORTHWEST WASECA, MN 56093		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
K 000	By emall to: Marian THE PLAN OF COIDEFICIENCY MUS FOLLOWING INFO.  1. A description of vito correct the deficition.  2. The actual, or proceed the deficition of vito correct the deficition.  3. The name and/or responsible for correct a reoccurred Lake Shore Inn Numbuilding with a particulation of the constructed at 4 difficulting was constructed at 4 difficulting was constructed to be of 1968, addition was that was determined to be of 1968, addition was that was determined construction. In 198 added to the South be Type II (111). In to the East Wing an II (111) construction and the 3 additions construction and mallowed for existing surveyed as one but The building is fully fire alarm system we corridors and space monitored for automotification.	RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:  what has been, or will be, done ency.  poposed, completion date.  If title of the person ection and monitoring to ence of the deficiency.  It is a 1-story all basement. The building was ferent times. The original ferent times. The original formation in 1960 and was for the times. The south Wing did to be of Type II(111) another addition was Wing and was determined to 1998, an addition was added to was determined to be Type of eet the construction type buildings, the facility was	KO	00		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		245388	B. WING	£	07/	23/2014
NAME OF PROVIDER OR SUPPLIER  LAKESHORE INN NURSING HOME			1	STREET ADDRESS, CITY, STATE, ZIP CODE 108 STH STREET NORTHWEST NASECA, MN 56093		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 000	census of 49 at the	time of the survey.  42 CFR Subpart 483.70(a) is	K 000	-		
K 050 SS=D	Fire drills are held a varying conditions, a The staff is familiar that drills are part of Responsibility for plassigned only to corqualified to exercise conducted between announcement may alarms. 19.7.1.2	t unexpected times under at least quarterly on each shift. with procedures and is aware f established routine. anning and conducting drills is mpetent persons who are leadership. Where drills are 9 PM and 6 AM a coded be used instead of audible	K 050	Fire drills times will be more random so that staff doesn't know when to a drill and must be prepared at all till Director of Maintenance, or designed be responsible. Results will be reported the QI committee quarterly for a year	expect mes. ee will erted to	8/29
	Based on documen interview, the facility were conducted one staff under varying trequired by 2000 NF This deficient practic residents.  Findings include:  On facility tour between 07/23/2014, the revidence mentation for the 2013 to July 2014) refollowing shifts were	een 9:00 AM and 12 noon on ew of the fire drills for the past 12 months (August evealed the drills for the past 12 months (August evealed the drills for the completed but did not times that the drills were	et a			

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		& MEDICAID SERVICES				0900-000	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245388		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED		
		B. WING			23/2014		
NAME OF PROVIDER OR SUPPLIER  LAKESHORE INN NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  108 8TH STREET NORTHWEST  WASECA, MN 56093				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETIO DATE	
K 050	Continued From pa	age 3	K 050	**************************************			
		30, 1520 and 1910 hours 0400 and 0130 hours		a a			
K 054	Administrator (MC)	ice was confirmed by the at the time of discovery. FETY CODE STANDARD	K 054			8-14 9130	
\$S=F	activating door hold maintained, inspect	detectors, including those dependences, are approved, ted and tested in accordance rer's specifications. 9.6.1.3		on the form regarding the sensitivity smoke alarms. The company will be re-evaluating the sensitivity of the as soon as possible. We are coord time that this can be done.  Director of maintenance, or design ensure that this work is done in a total smoke and the sensitivity of th	e alarms linating a ee will imely		
	Based on documer interview, the facility system in accordant	s not met as evidenced by: ntation review and staff y failed maintain the fire alarm nce with the requirement 1999 '-3.2. The deficient practice esidents.		fashion. The work done will be rep the QI committee once completed.			
	Findings include:	× :4					
Y I	07/23/2014, the revereport of the fire ala Security dated 2/6/2 recorded for each at the range of .62 to not included on the annual report dated sensitivity range was report indicated the the range of 1.0 to 4	veen 9:00 AM and 12 noon on view of the annual inspection arm system from Flex-Comm 14. The sensitivity was amoke detector and were in .64. The the factory range was above report. I reviewed the 12/9/2010, the factory is included on this report. The smoke detectors should be in 4.0. So according to the port all the detectors failed.	196	4			

Event ID: 2V6G21

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(XS) DATE SURVEY COMPLETED	
		245388	B. WING			07/2	23/2014
NAME OF PROVIDER OR SUPPLIER  LAKESHORE INN NURSING HOME				10	TREET ADDRESS, CITY, STATE, ZIP CODE 08 BTH STREET NORTHWEST (ASECA, MN 56093		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE .	(X5) COMPLETION DATE
K 054			K	54			
K 062 SS=F	Administrator (MC) NFPA 101 LIFE SA Required automatic continuously mainta condition and are in	tice was confirmed by the at the time of discovery. FETY CODE STANDARD sprinkler systems are sined in reliable operating aspected and tested	<b>K</b> (	)62	The documentation of the sprinkler tests was not completed properly. T paperwork is filled out now. The Director of Maintenance or his designee will put this test on his quatest checklist. These tests have alw	he arterly	8/29
1	periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation and staff Interview, the facility falled 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.			8	been done, but the paperwork has been lacking. The updated checklist will be given to the QI committee to review for accuracy. 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 replace the gauge.		
	07/23/2014, a revie inspection records in 1. No documentation and 2014 - 1st quartests  2. The water gauge written date of 2-06	veen 9:00 AM and 12 noon on w of the annual fire sprinkler revealed the following: on for the 2013 - 4th quarter fire sprinkler quarterly flow on the main riser has a hand There was no documentation as been calibrated or replaced					

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	NO LON MEDIONINE	& MEDICAID SERVICES				IND INO.	0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  245388		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING			(X3) DATE SURVEY COMPLETED 07/23/2014		
							NAME OF
LAKESH	IORE INN NURSING H	IOME	a	108 8TH STREET NO WASECA, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORR	IS PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPL DEFICIENCY)	BE	(X5) COMPLETION DATE
K 062 K 144 SS=F	These deficient pra Administrator (MC) NFPA 101 LIFE SA Generators are insp	ctices were confirmed by the at the time of discovery. FETY CODE STANDARD Dected weekly and exercised inutes per month in	K0 K1	Our weekly load not completed a the last year. The misunderstood has the test is now The staff have be	test for the generate couple of times throw the maintenance stafflow the test could be being done every ween educated as to st can be completed	oughout f e done. eek. how	8/29
	Based on documer interview, the facility emergency generative requirements of 200 NFPA 110 Chapter 6 could affect all 49 reference in the facility tour betw 07/23/2014, documer inspection logs (July diesel emergency gweekly operational inweeks of 9/2/13,11/2.  This deficient practice	een 9:00 AM and 12 noon on entation review of the weekly 2013 to July 2014) for the enerator revealed that the nspection were missed for the	X X X X X X X X X X X X X X X X X X X				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/06/2014 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPFLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED A. BUILDING 01 - MAIN BUILDING 01 245388 B. WING 07/23/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 108 8TH STREET NORTHWEST LAKESHORE INN NURSING HOME WASECA, MN 56093 SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) K 144 Continued From page 6 K 144 \*TEAM COMPOSITION\* Gary Schroeder, Life Safety Code Spc.



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

Lakeshore Inn Nursing Home August 6, 2014 Page 2

### <u>Informal Dispute Resolution</u> - 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

Lakeshore Inn Nursing Home August 6, 2014 Page 3

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

Lakeshore Inn Nursing Home August 6, 2014 Page 4

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:

Lakeshore Inn Nursing Home August 6, 2014 Page 5

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

Kumala Fiske Downing

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	(X3) DATE SURVEY COMPLETED			
		00682	B. WING		07/24/201	14
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
LAKESH	ORE INN NURSING H	OME	STREET NO MN 56093	RTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE CON	(X5) MPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency form of corrected shall with a schedule of the Minnesota Department of the Minnesota Department of the Minnesota MN Rumber and MN Rumber and MN Rumber and mumber	nether a violation has been				
	You may request a that may result from orders provided that the Department with	hearing on any assessments non-compliance with these to a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	surveyors of this De above provider and were issued. Wher please sign and dat page in the line ma	7S: 23rd and 24th, 2014, epartment's staff visited the the following licensing orders a corrections are completed, the on the bottom of the first rked with "Laboratory er/Supplier Representative's		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal s Tag numbers have been assigned Minnesota state statutes/rules for Homes.	oftware.	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		00682	B. WING		07/24	1/2014
	PROVIDER OR SUPPLIER  ORE INN NURSING H	108 8TH S	ORESS, CITY, S STREET NO MN 56093	STATE, ZIP CODE RTHWEST		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	signature." Make a records and return below: Minnesota I of Compliance Mon Certification Progra Marshall, MN 56256 Minnesota Departmenthe State Licensing federal software. Ta assigned to Minnes Nursing Homes.  The assigned tag in column entitled "ID statute/rule out of c "Summary Statementhe and replaces the "T correction order. The findings which are in after the statementhe evidence by." Followare the Suggested Time period for Corplease DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEATHERE IS NO RECOPLAN OF CORRECT	copy of these orders for your the original to the address Department of Health, Division altoring, Licensing and m, 1400 E. Lyon Street, and the complete of Health is documenting Correction Orders using any numbers have been not a state statutes/rules for the compliance is listed in the compliance is listed i	2 000	The assigned tag number appears far left column entitled "ID Prefix". The state statute/rule number and corresponding text of the state statut out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. To column also includes the finding are in violation of the state statute statement, "This Rule is not met a evidenced by." Following the surfindings are the Suggested Metho Correction and the Time Period Forection.  PLEASE DISREGARD THE HEAD THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FEDERAL DEFICIENCIES ONLY WILL APPEAR ON EACH PAGE.  THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION STATUTES/RULES.	Tag." I the atute/rule cies" I this swhich after the is veyors id of or DING OF TO THIS	
2 565	Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			
	Supp. 3. Use. A co	omprehensive plan of care				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING: (X3)			(X3) DATE SURVEY COMPLETED	
		00682	B. WING		07/2	4/2014	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
LAKESH	ORE INN NURSING H	OME	STREET NO MN 56093	RTHWEST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE	
2 565	care of the resident	personnel involved in the	2 565				
	by: Based on observati review the facility fa services according of 3 residents (R19 dependent upon sta failed to properly po	on, interview and document alled to provide grooming to the written plan of care for 2 & R24) reviewed who were aff for grooming needs and esition 1 of 1 resident (R22) at risk for aspiration.					
	7/7/14, identified that	num data set (MD) dated at R19 had the following ia and Parkinson's disease.					
	10/15/12, under the specified: nail care for grooming and ba assist with 1 staff to	of care for R19, dated heading of Nurse Aide, with bath; and approaches athing included-extensive assist. Review of the bath that R19 received a bath					
	seated in a wheelch that R19 had untrim sharp edges. Durin afternoon on 7/22/1 fingernails remained edges. It was obse	on 7/21/14, at 6:44 p.m. while hair in her room. It was noted had fingernails with verying an observation the following 4, at 2:35 p.m. R19's d untrimmed with sharp erved again on 7/23/14, at 9:51 pernails remained untrimmed hes.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		00682	B. WING		07/	24/2014
	PROVIDER OR SUPPLIER	IOME 108 8TH	ODRESS, CITY, S			
		WASECA	N, MN 56093			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 565	Continued From pa	ae 3	2 565			
	An interview was co a.m. with nursing as observing the cond NA-A verified that R with very sharp edg been followed as w Review of the minir	onducted on 7/24/14, at 7:19 ssistant (NA)-A while ition of R19's fingernails. R19 had untrimmed fingernails jes. The plan of care had not				
	dementia and paral disease).	ysis agitans (Parkinson's				
	under the heading of care with bath. The dependent upon 1 stace/hands, brushe and does peri-care; assist, staff dresse body. Review of the	of care for R24, dated 2/15/13 of Nurse Aide, it identified: naile approach included-grooming staff assist, staff washes is teeth, shaves, combs hair dressing: dependent upon 1 ps/undresses upper and lower be bath schedule verified that the every Tuesday which would 14.	I			
	p.m. with R24's fam learned that during following: long and	interview on 7/21/14, at 3:59 nily member (F)-A it was frequent visits she noted the dirty fingernails, food stained kin and at times seated in a				
	7/23/14, at 11:35 a. fingernails that were observation on the a.m. R24 was noted	7/21/14, at 2:03 p.m. and on m. that R24 had long, dirty e in need of grooming. During morning of 7/24/14, at 7:14 d to have dirty, long fingernails th had been provided on prior.				
		ervation on 7/22/14, at 12:30 ed in a geri-chair in the dining				

Minnesota Department of Health

STATE FORM 2V6G11 If continuation sheet 4 of 19

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00682	B. WING		07/2	4/2014
	PROVIDER OR SUPPLIER	108 8TH	STREET NO., MN 56093	STATE, ZIP CODE RTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	room and a towel, was noted tucked in and partially undern 1:03 p.m. R24 was geri-chair in the hal station wearing a sh front and was seate stained a red color.  An interview on 7/2 of nursing (DON)-A that R24 eats a lot of in soiled fingernails.  An interview was coa.m. with nursing as observation of R24 dirty, long fingernail shirt had visible spill.  During an interview registered nurse (R R24 had dirty, long the shirt had stained transported R24 int shirt.  R22 had diagnoses set (MDS) as noted (L) [left] above the k diabetes.  The plan of care dathe following was not (1) Problem: Self C decreased mobility; and diabetes. Apprint	which contained spilled food, not the left side of the chair neath R24. On 7/22/14, at observed seated in a lway by the south nursing nirt with spilled food on the ed on an incontinence pad,  3/14, at 3:15 p.m. with director and DON-B, it was verified of finger foods which resulted of finger foods which resulted sistant (NA)-A during. NA-A verified that R24 had as on both hands and R24's led liquid on it.  on 7/24/14, at 7:21 a.m. with N)-C, it was also verified that fingernails on both hands and diquid. Subsequently, RN-C on his room and changed the slisted on the minimum data and the decrease amputation (AKA) and the decrease of the listed to Hx of (L) AKA; depression; roach dated 4/30/13, Nurse endent after staff provides tray	2 565			

Minnesota Department of Health

STATE FORM 2V6G11 If continuation sheet 5 of 19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00682	B. WING		07/	24/2014
NAME OF F	PROVIDER OR SUPPLIER	STREE	Γ ADDRESS, CITY,	STATE, ZIP CODE	·	
LAKESH	ORE INN NURSING H	(OME	TH STREET NO CA, MN 56093	RTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	Hx of (L) above the memory; depressio (4/25/14)wedge prevent resident from (3) Problem dated alteration. Approach and the following or the following or the following or derivation of the July 201 the following or derivation precaution upright-all or al intake a time; (4.) Eat sloom The flow sheet listed cushion in w/c (who initialed by staff on thru 7/23/14, which with the physician of the dining room it was at the dining roo	related to impaired mobility; knee amputation; impaired on; diabetes. Approach: data cushion in wheelchair to om sliding forward; and 1/28/14: Potential for nutritic ch: Assisted feeding table, a trained feeding assistant of the sheet, which was identified 4 plan of care plan, identified 5 from medical doctor (MD)-ons: (1.) Must be alert; (2.) ke; (3.) Small bites/sips one wly; and (5.) Good oral care detectair). The flow sheet was ceed the electrical compliance orders as listed 1-5.  Ition on 7/21/14, at 5:15 p.m. was noted that R22 was air, in a reclined position. In the action of the additional pillow several pillows behind his ved that R22 remained ochair but leaned to the left cation of the additional pillow as observed to consume a seand coughed repeatedly in	n ue as d A: Sit at e. in he			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMP	SURVEY LETED
		00682	B. WING		07/2	4/2014
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
LAKESH	ORE INN NURSING H	IOME	STREET NO MN 56093	RTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	noted to be reclined approximately a 50 breakfast, R22 was Trained medication until the airway was immediate area.  During an observat R22 was seated in the noon meal. R2 12:26 p.m. which consider was noted that R22 without difficulty. A cold broccoli salad of broccoli. R22 rep.m. R22 drank a sepeatedly, cleared intermittently cough noted in his throat.  An observation on conducted while R2 geri-chair in the din again reclined to apangle. The meal consyrup, sausage link R22 fed himself and food items. At 8:19 holding a fork which on it. R22 was ider	the dining room and was again d in the geri chair at degrees angle. While eating anoted to repeatedly cough. aid (TMA)-B monitored R22 cleared, and then left the ion on 7/22/14, at 12:20 p.m. the reclined geri-chair during 2 received his food tray at consisted of chicken, crinkle cut broccoli salad and buttered in was cut up by NA-C and it was able to feed himself to 12:33 p.m. R22 consumed a which contained large pieces peatedly coughed. At 12:48 ip of water, coughed his airway. R22 continued to in, with audible loose phlegm  7/23/14, at 8:00 a.m. was 22 was seated in a reclined ing room. The geri-chair was peroximately a 50 degree consisted of french toast with its, juice, water and coffee. In the geri-chair was a peroximately a solution of the geri-chair was peroximately a solution to staff offered to cut up his it a.m. R22 was observed in had an entire sausage link intified to repeatedly cough and way. At 8:34 a.m. R22	2 565			
	appeared to be coun of water to R22 bed reach due to being An interview on 7/2	ighing. NA-D handed a glass cause his water was out of his in a reclined position.  3/14, at 2:55 p.m. with DON-A diverified the plan of care had				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY
		00682	B. WING		07/2	24/2014
	PROVIDER OR SUPPLIER	108 8TH	DRESS, CITY, S STREET NOI , MN 56093	STATE, ZIP CODE RTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
2 565	not been followed a wedge cushion in h for positioning in an SUGGESTED MET director of nursing of system to educate a system to ensure sidirected by the writt of nursing or design compliance.	ge 7 as written for R22 related to a is wheel chair and the need upright wheel chair.  THOD OF CORRECTION: The or designee could develop a staff and develop a monitoring taff are providing care as ten plan of care. The director nee could monitor for	2 565			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car- custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			
	by: Based on observati review the facility fa positioning during n	on, interview and document alled to provide proper neal time for 1 of 1 resident to was at risk for aspiration.				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		SURVEY PLETED	
		00682	B. WING		07/	24/2014
	PROVIDER OR SUPPLIER	IOME 108 8TH	ODRESS, CITY, S' STREET NOF A, MN 56093			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 8	2 830			
	set (MDS) as noted (L) [left] above the I depression; and dia During an observathe dining room it win a geri-chair, in a geri-chair was recliidegree angle. At 5 cough repeatedly a loose sounding phles wallowed. At 5:23 walked over to R22 forward by placing shack. It was observed in the geriside after the applic At 5:30 p.m. R22 w	tion on 7/21/14, at 5:15 p.m. in vas noted that R22 was seated reclined position. The ned at approximately 50:19 p.m. R22 was noted to nd cleared his airway after egm was expectorated and p.m. nursing assistant (NA)-C and attempted to prop him several pillows behind his ved that R22 remained chair but leaned to the left cation of the additional pillows. as observed to consume a and coughed repeatedly in an				
	eating breakfast in noted to be reclined approximately a 50 breakfast, R22 was Trained medication until the airway was immediate area.  During an observat R22 was seated in the noon meal. R2 12:26 p.m. which cosweet potato fries,	a.m. R22 was observed while the dining room and was again d in the geri chair at degrees angle. While eating a noted to repeatedly cough. aid (TMA)-B monitored R22 cleared, and then left the ion on 7/22/14, at 12:20 p.m. the reclined geri-chair during 2 received his food tray at onsisted of chicken, crinkle cut broccoli salad and buttered in was cut up by NA-C and it				

Minnesota Department of Health

STATE FORM 2V6G11 If continuation sheet 9 of 19

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00682	B. WING		07/2	4/2014
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
LAKESH	IORE INN NURSING H	IOME	STREET NO	RTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	was noted that R22 without difficulty. A cold broccoli salad of broccoli. R22 re the meal. At 12:48 coughed repeatedly continued to interm loose phlegm noted. An observation on conducted while R2 geri-chair in the din feeding table with swas again reclined angle. The meal consyrup, sausage link R22 fed himself and food items. At 8:19 holding a fork which on it. R22 was idented then cleared his air appeared to be couphlegm so NA-D has because his water being in a reclined. Review of the occupation in a reclined occupation Therapidentified the follow Statement: Nursing forward in w/c [whe set up to prevent sliding t	2 was able to feed himself at 12:33 p.m. R22 consumed a which contained large pieces peatedly coughed throughout p.m. R22 drank a sip of water, y and cleared his airway. R22 attently cough, with audible d in his throat.  7/23/14, at 8:00 a.m. was 22 was seated in a reclined at a reclined at a reclined at a proximately a 50 degree consisted of french toast with as, juice, water and coffee. In do staff offered to cut up his a am. R22 was observed the had an entire sausage link and the way. At 8:34 a.m. R22 aughing and not clearing the landed a glass of water to R22 was not within reach due to	2 830			

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00682 B. WING 07/24/201	
00682 B. WING 07/24/201	4/2014
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
LAKESHORE INN NURSING HOME  108 8TH STREET NORTHWEST  WASECA, MN 56093	
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) COMPLETE DATE
2 830  Continued From page 10  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 now sitting upright in w/c with no more concerns from nursing". "Pt was sliding forward in w/c." "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	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED	
		00682	B. WING		07/	24/2014
	PROVIDER OR SUPPLIER	IOME 108 8TH	DRESS, CITY, S' STREET NOR , MN 56093			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 830	wheelchair to prever forward. The # 12-dated 4/29/14 ident wheelchair/chair for [difficulty swallowing.]  The plan of care day the following was now (1) Problem: Self Codecreased mobility; [left] above the kneediabetes. Approach Aide-Eating: Independent of the July 201 the following deprevent resident from (3) Problem dated alteration. Approach may not be fed by a to dysphagia.  Review of the flow spart of the July 201 the following order Aspiration precaution upright-all oral intake a time; (4.) Eat slot The flow sheet listed cushion in w/c (whe initialed by staff one thru 7/23/14, which with the physician of the During an observat R22 was located in	ent resident from sliding Nutrition CAA documentation ified: proper positioning in r dining due todysphagia g].  Ited 5/6/14, was reviewed and oted: are Deficit: related to r depression; Hx [history] of (L) e amputation; depression; and h dated 4/30/13 Nurse endent after staff provides tray  4/30/14: Potential elated to impaired mobility; knee amputation; impaired n; diabetes. Approach: dated cushion in wheelchair to om sliding forward; and 1/28/14: Potential for nutrition ch: Assisted feeding table, a trained feeding assistant due  sheet, which was identified as 4 plan of care plan, identified s from medical doctor (MD)-A: ons: (1.) Must be alert; (2.) Sit xe; (3.) Small bites/sips one at wly; and (5.) Good oral care. d treatments as: wedge elchair). The flow sheet was ce on every shift from 7/1/14 indicated staff compliance				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	E CONSTRUCTION		SURVEY PLETED
	00682	B. WING		07/	24/2014
NAME OF PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	1 0172	L <del>4</del> /2014
LAKESHORE INN NURSING H	OME 108 8TH	STREET NO			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
the ROHO cushion  Review of orders da certified nurse pract following under the Dysphagia. An inter 7/23/14, at 10:55 a. stated with a dyphagosition while in the risk for aspiration proposition while in the risk for aspiration proposition while in the risk. She further ad a reclining geri-chai wiggle while seated She denied any known had been utilized in geri-chair.  During a telephone a.m. speech langual verified that R22 had evaluated by speech An interview on 7/23 and DON-B verified CNP-A the need to due to the risk of as occupational therapof a wedge cushion wheelchair.  SUGGESTED MET The Director of Nurselector of Nurselector general times.	was evident in either chair but was present.  ated and signed 6/18/14, by titioner (CNP)-A identified the Cumulative Diagnosis List: erview was conducted on m. with CNP-A and it was gia diagnosis, the reclined geri-chair could put R22 at neumonia.  on 7/23/14, at 12:00 noon F-A en aware of R22's choking Ided that staff position R22 in r due to a tendency of R22 to and staff were afraid of a fall. eviledge the wedge cushion either the wheelchair or interview on 7/23/14, at 9:11 age pathologist (SLP)-A d not been seen nor h therapy (ST) for years.  3/14, at 2:55 p.m. with DON-A they needed to discuss with conduct a swallow evaluation spiration and the need for an ay evaluation related to the use	2 830	DETIGIENC!)		

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00682	B. WING		07/2	4/2014
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
LAKESH	ORE INN NURSING H	IOME	STREET NO , MN 56093	KIHWESI		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 13	2 830			
	designee could devensure residents re	pirector of Nursing or her velop a monitoring system to eceive the appropriate care.  R CORRECTION: Twenty-one				
2 860	MN Rule 4658.0520 Proper Nursing Car	0 Subp. 2 F. Adequate and re; Hands-Feet	2 860			
	proper care. The cadequate and proper care and att	or determining adequate and riteria for determining er care include: ention to hands and feet. nails must be kept clean and				
	by: Based on observative review the facility facare for 2 of 3 residuals.	ent is not met as evidenced ion, interview and document ailed to provide personal nail dents (R19 & R24) reviewed nt upon staff for nail grooming				
	Findings include:					
	7/7/14, identified th diagnoses: dement R19 was observed seated in a wheelch that R19 had untrin sharp edges. Durir afternoon on 7/22/1 fingernails remaine edges. It was observed.	mum data set (MD) dated at R19 had the following ia and Parkinson's disease. on 7/21/14, at 6:44 p.m. while nair in her room. It was noted med fingernails with very ng an observation the following 14, at 2:35 p.m. R19's d untrimmed with sharp erved again on 7/23/14, at 9:51 pernails remained untrimmed				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
	00682	B. WING		07/	24/2014
NAME OF PROVIDER OR SUPPLIER  LAKESHORE INN NURSING HO	OMF 108 8TH	DRESS, CITY, ST STREET NOR , MN 56093	,		
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
the heading of Nurse with bath; Approach included-extensive a Review of the bath s received a bath ever.  An interview was cor a.m. with nursing as observing the condit NA-A verified that R with very sharp edge.  Review of the MDS i following diagnoses: paralysis agitans (Pa During a telephone in p.m. with R24's familearned that during fi following: long and of the state of the s	of care dated 10/15/12, under e Aide, it specified: nail care hes for grooming and bathing assist with 1 staff to assist. Schedule identified that R19 by Thursday.  Inducted on 7/24/14, at 7:19 sistant (NA)-A while ion of R19's fingernails. 19 had untrimmed fingernails es.  Identified that R24 had the example Lewy Body dementia and earkinson's disease).  Interview on 7/21/14, at 3:59 illy member (F)-A it was requent visits she noted the dirty fingernails.  In that R24 had long, dirty in need of grooming. During norning of 7/24/14, at 7:14 to have dirty, long fingernails had been provided on ior.  In the control of the director and DON-B verified that R24 had long, with director and DON-B verified that R24 had long which resulted in soiled	2 860			

IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
	00682	B. WING		07/2	4/2014
	OMF 108 8TH	STREET NO			
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETE DATE
dirty, long fingernail During an interview registered nurse (R R24 had dirty, long Review of the plane the heading of Nurs with bath; Approac 1 assist, staff wash bath schedule verifi every Tuesday and Tuesday, 722/14.  A policy on nail care 10:02 a.m. and (DC able to locate any s  SUGGESTED MET The DON could insi as to their responsil residents with assis to facility policy. The ensure the care is b and take action as in	s on both hands.  on 7/24/14, at 7:21 a.m. with N)-C, it was also verified that fingernails on both hands.  of care dated 2/15/13, under se Aide, it identified: nail care h-grooming: dependent upon es face/hands. Review of the ed that R24 received a bath had received a bath on  e was requested on 7/24/14, at N)-B stated that she was not uch policy.  THOD FOR CORRECTION: ure that staff are re-inserviced bility to provide dependent stance with nail care according e DON could conduct audits to being provided as indicated needed.	2 860			
Subp. 2. Criteria for proper care. The cadequate and proper H. Clean clot Residents must be	r determining adequate and criteria for determining er care include: hing and a neat appearance. dressed during the day	2 870			
	PROVIDER OR SUPPLIER  ORE INN NURSING H  SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE  Continued From pa dirty, long fingernail  During an interview registered nurse (R R24 had dirty, long  Review of the plan of the heading of Nurs with bath; Approac 1 assist, staff wash- bath schedule verifice every Tuesday and Tuesday, 722/14.  A policy on nail care 10:02 a.m. and (DC able to locate any s  SUGGESTED MET The DON could insi as to their responsil residents with assist to facility policy. The ensure the care is be and take action as in  TIME PERIOD FOF (21) days.  MN Rule 4658.0520 Proper Nursing Care  Subp. 2. Criteria for proper care. The coadequate and proper H. Clean clot Residents must be	ORE INN NURSING HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15 dirty, long fingernails on both hands.  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.  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.  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.  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.  TIME PERIOD FOR CORRECTION: Twenty-one	ORE INN NURSING HOME  STREET ADDRESS, CITY, S  ORE INN NURSING HOME  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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.  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.  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.  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.  TIME PERIOD FOR CORRECTION: Twenty-one (21) days.  MN Rule 4658.0520 Subp. 2 H. Adequate & Proper Nursing Care-CleanClothing  Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:  H. Clean clothing and a neat appearance. Residents must be dressed during the day	OF CORRECTION    DENTIFICATION NUMBER:   B. WING   CROSS-REFERENCED TO HE APPRO CROSS-REFERENCED TO HE APPRO DEFICIENCY   C. WING   C. W	OF CORRECTION    DOBS2   B. WING

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-	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00682	B. WING		07/2	4/2014
	PROVIDER OR SUPPLIER  ORE INN NURSING H	108 8TH	DRESS, CITY, S STREET NO MN 56093	STATE, ZIP CODE RTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 870	Continued From pa	ge 16	2 870			
	by: Based on observati review the facility fa for 1 of 3 residents dependent upon sta  Findings include:  Review of the MDS following diagnoses paralysis agitans (F  During a telephone p.m. with R24's fam learned that during following: food stai  On 7/22/14, at 1:03 seated in a geri-cha nursing station wea the front.  An interview was co a.m. with nursing as observation of R24 shirt with spilled liqu a.m  During an interview registered nurse (R R24 had a shirt with	p.m. R24 was observed air in the hallway by the south ring a shirt with spilled food on onducted on 7/24/14, at 7:14 ssistant (NA)-A during NA-A verified that R24 had a uid on it on 7/24/14 at 7:14  on 7/24/14, at 7:21 a.m. with N)-C, it was also verified that it visible spilled liquid on it. C transported R24 to his room				
	Review of the plan identified that R24 v	of care dated 2/15/13, was dependent upon staff for ses/undresses upper and				

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-	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE :	
		00682	B. WING		07/2	4/2014
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	1 4172	
I AKESHORE INN NURSING HOME			STREET NO , MN 56093	RTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 870	Continued From pa	ge 17	2 870			
	The DON could ensire-inserviced as to dependent resident personal care per faconduct audits to en provided as indicated	HOD OF CORRECTION: sure that staff are their responsibility to provide s with assistance with acility policy. The DON could asure the care is being ed and take action as needed.				
21685	MN Rule 4658.1415 Housekeeping, Ope	5 Subp. 2 Plant eration, & Maintenance	21685			
	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, rs, ceilings, all furnishings, ment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.				
	by: Based on observati review the facility fa cleanliness of the clean down the hallw. This had the potent	arpet located in the front entry ay into the dining room area. ial to affect all 49 residents as this multi-use area for				
	Findings include:					
	7/21, at 2:00 p.m. 7	s on all days of the survey /22, 7/23, at 9:30 a.m. and nat the carpet leading from the				

	AND DI AN OF COPPECTION INDENTIFICATION NUMBER:		E CONSTRUCTION (X		(3) DATE SURVEY COMPLETED	
		00682	B. WING		07/	24/2014
	PROVIDER OR SUPPLIER	OMF 108 8TH	DRESS, CITY, S STREET NO , MN 56093	STATE, ZIP CODE RTHWEST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
21685	front entryway into the heavily soiled. A so the center of the carbination of the carbination of the carpet cleaning on 7/23/14, at 10:25 verified the carpet in hallway into the dinates of the carpet of the carpet of the carpet of the carpet of the carpet. The carbination of the HS stated that transported from the carpet. The carbination of the carpet of the carpe	the dining room appeared biled pathway was noted down rpet.  on 7/23/14, at 9:30 a.m. the ctor (ED) reported the exister (HS) was in charge of During an follow-up interview a.m. with the HS, she in the entry and down the ing area was heavily soiled. Utility carts were routinely ne dietary/staff utility room adjacent to the main kitchen aused the soiled path noted on the cleaning schedule was is and it was noted that is had been cleaned every 5 to be month, the carpets remained are followed in the company of the could be roomed and grounds to the company of the could be roomed as a safe, clean, ent. The DON or designee could develop monitoring systems	21685			