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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 46RJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00594

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245215**
2.STATE VENDOR OR MEDICAID NO.
(L2) **001043000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKESHORE INC**
(L4) **4002 LONDON ROAD**
(L5) **DULUTH, MN** (L6) **55804**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/05/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Cynthia Stramel, HFE NEII 10/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/12/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1977
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/16/2015
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5215

On June 25, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the facilitys plan of correction and on October 5, 2015 the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 15, 2015 and a Federal Monitoring Survey (FMS) completed on June 11, 2015. We presumed, based on theirr plan of correction, that the facility had corrected these deficiencies as of August 14, 2015. Based on our PCR, we have determined that the facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 15, 2015 and the FMS completed June 11, 2015, effective August 14, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in the CMS letter of June 23, 2015. The CMS Region V Office concurs and has authorized this Department to notify the facility of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 15, 2015, be rescinded. (42 CFR 488.417(b))

As the facility was advised in the CMS letter of June 23, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 15, 2015 due to denial of payment for new admissions. Since the facility attained substantial compliance on August 15, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Refer to the CMS 2567b for health, LSC and FMS.

Effective August 14, 2015, the facility is certified for 60 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245215

October 11, 2015

Mr. John Korzendorfer, Administrator
Lakeshore Inc
4002 London Road
Duluth, Minnesota 55804

Dear Mr. Korzendorfer:

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 August 14, 2015 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 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.

Feel free to contact me if you have questions related to this letter / eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Electronically delivered
October 12, 2015

Mr. John Korzendorfer, Administrator
Lakeshore Inc
4002 London Road
Duluth, Minnesota 55804

RE: Project Number S521526, F521525

Dear Mr. Korzendorfer:

On May 31, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 15, 2015. 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 June 11, 2015, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were 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 June 23, 2015, CMS forwarded the results of the FMS and notified you that your facility was not in substantial compliance with the Federal requirements for nursing homes participation in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 15, 2015 (42 CFR 488.417(b))

Also, the CMS Region V Office notified you in their letter of June 23, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 15, 2015.

On June 25, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 5, 2015 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 May 15, 2015 and a Federal Monitoring Survey (FMS) completed on June 11, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 14, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 15, 2015 and the FMS completed June 11, 2015, effective August 14, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in the CMS letter of June 23, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 15, 2015, be rescinded. (42 CFR 488.417(b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective August 15, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 15, 2015, is to be rescinded.

As you were advised in the CMS letter of June 23, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 15, 2015 due to denial of payment for new admissions. Since your facility attained substantial compliance on August 15, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245215	A. Building B. Wing	6/25/2015

Name of Facility	Street Address, City, State, Zip Code
LAKESHORE INC	4002 LONDON ROAD DULUTH, MN 55804

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	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **06/22/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/22/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/22/2015**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **06/22/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By _____ **State Agency**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/15/2015	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

Form Approved LSC
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245215	02 - NEW REPLACEMENT BLDG	10/5/2015

Name of Facility	Street Address, City, State, Zip Code
LAKESHORE INC	4002 LONDON ROAD DULUTH, MN 55804

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0144	06/26/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/mm	10/12/2015	27200	10/05/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
5/12/2015			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245215	A. Building B. Wing **02 - NEW REPLACEMENT BLDG**	10/5/2015

Name of Facility	Street Address, City, State, Zip Code
LAKESHORE INC	4002 LONDON ROAD DULUTH, MN 55804

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	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **08/13/2015**	ID Prefix	Correction Completed **08/13/2015**	ID Prefix	Correction Completed **08/13/2015**
Reg. # **NFPA 101** LSC K0011		Reg. # **NFPA 101** LSC K0012		Reg. # **NFPA 101** LSC K0017	
ID Prefix	Correction Completed **08/14/2015**	ID Prefix	Correction Completed **08/13/2015**	ID Prefix	Correction Completed **08/13/2015**
Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0020		Reg. # **NFPA 101** LSC K0023	
ID Prefix	Correction Completed **08/13/2015**	ID Prefix	Correction Completed **08/13/2015**	ID Prefix	Correction Completed **08/13/2015**
Reg. # **NFPA 101** LSC K0025		Reg. # **NFPA 101** LSC K0033		Reg. # **NFPA 101** LSC K0038	
ID Prefix	Correction Completed **08/13/2015**	ID Prefix	Correction Completed **08/13/2015**	ID Prefix	Correction Completed **08/14/2015**
Reg. # **NFPA 101** LSC K0045		Reg. # **NFPA 101** LSC K0048		Reg. # **NFPA 101** LSC K0050	
ID Prefix	Correction Completed **08/13/2015**	ID Prefix	Correction Completed **08/13/2015**	ID Prefix	Correction Completed **08/13/2015**
Reg. # **NFPA 101** LSC K0051		Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0069	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GS/mm	10/12/2015	27200	10/05/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245215	A. Building B. Wing **02 - NEW REPLACEMENT BLDG**	10/5/2015

Name of Facility	Street Address, City, State, Zip Code
LAKESHORE INC	4002 LONDON ROAD DULUTH, MN 55804

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	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **08/13/2015**	ID Prefix	Correction Completed **08/13/2015**	ID Prefix	Correction Completed **08/13/2015**
Reg. # **NFPA 101** LSC K0071		Reg. # **NFPA 101** LSC K0144		Reg. # **NFPA 101** LSC K0154	
ID Prefix	Correction Completed **08/13/2015**				
Reg. # **NFPA 101** LSC K0155					

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/mm	10/12/2015	27200	10/05/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/11/2015

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245215	LAKESHORE INC

Type of Survey (select all that apply):

D					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 27200	10-05-2015	10-05-2015	1.00	0.00	2.00	0.00	2.50	2.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25 0.00

Total Clerical/Data Entry Hours..... 0.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 46RJ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00594

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245215**

2.STATE VENDOR OR MEDICAID NO.
(L2) **001043000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKESHORE INC**
(L4) **4002 LONDON ROAD**
(L5) **DULUTH, MN** (L6) **55804**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/15/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Cynthia Stramel, HFE NEII — 06/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 06/15/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1977
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 06/16/2015 Co.

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 31, 2015

Mr. John Korzendorfer, Administrator
Lakeshore Inc
4002 London Road
Duluth, Minnesota 55804

RE: Project Number S5215026

Dear Mr. Korzendorfer:

On May 15, 2015, 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>Electronic 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;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

Chris Campbell, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: chris.campbell@state.mn.us

Phone: (218) 302-6151
Fax: (218) 723-2359

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 June 24, 2015, 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 June 24, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC 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 ePoC 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 ePoC 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 ePoC 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 ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 15, 2015 (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 November 15, 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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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
pat.sheehan@state.mn.us

Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245215	A. BUILDING _____ B. WING _____	05/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE INC	4002 LONDON ROAD DULUTH, MN 55804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		6/22/15

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

Electronically Signed | 06/09/2015

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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F 156	Continued From page 1 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156		

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide notification of end of skilled services and Medicare non-coverage to 2 of 4 residents (R208; R75) reviewed for medicare notices. Findings include: R208 face sheet indicated R208 was admitted to the facility on 11/18/14, for rehabilitation services, and diagnoses included fatigue and congestive heart failure. The face sheet also indicated R208 was discharged on 12/3/14. The business office consultant (BOC) stated services ended on 12/3/14 and verified R208 should have received notification of end of skilled services and Medicare non-coverage on 12/1/14.	F 156	F156 1. Corrective Action: A. Residents #208 & 75 have discharged. 2. Corrective Action as it applies to Other Residents: A. The policy and procedure for Medicare Non-Coverage Notification/Demand Bill/Benefit Exhaust Claims dated 10/2007 has been reviewed. B. The Business Office Consultant will educate the Business Office Manager, DON, and Nurse Managers on Which Notice to Give, Beneficiary Notice Summary, and Medicare Denial training June 9th and June 11th 2015.. C. Notice of Medicare Non-Coverage will	

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F 156	Continued From page 3 R75 face sheet indicated R75 was admitted to the facility on 10/20/14, for rehabilitation services and diagnoses included a history of a fall. The face sheet indicated R75 was discharged on 11/21/14. The BOC stated services ended on 11/21/14 and verified R75 should have received notification of the end of skilled services and Medicare non-coverage on 11/19/14. During an interview and a document review on 05/14/2015, at 1:42 p.m. the BOC stated the notification of end of skilled services and Medicare non-coverage was delivered to the resident 48 hours prior to the end of services. The BOC stated prior to the end of January 2015, the business office delivered the notifications for end of skilled services and Medicare non-coverage to the appropriate residents. The BOC verified that in November and December of 2014, the notifications for end of skilled services should have been delivered by the business office The facility policy and procedure for Medicare Non-Coverage Notification/Demand Bill/Benefit Exhaust Claims dated 10/2007, indicated a notice will be delivered to the resident within 48 hours advising them that their Medicare Part A coverage will end.	F 156	be issued at least 48 hours in advance to every resident who has been decided that Medicare Coverage will end . 3. Date of Completion: June 22, 2015. 4. Reoccurrence will be Prevented by: A. Staff education provided on June 9th and June 11th 2015. B. Business Office Manager will conduct random audits 2 times a week for 1 month, then weekly audits for one month, then monthly audits. Findings will be reported to the QAPI team for review and discussion. 5. The Correction will be Monitored by: A. Business Office Manager or designee. B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		6/22/15

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F 309	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish emergency medical interventions for 1 of 1 residents (R365) reviewed for dialysis. Findings include: R365's Admission Record identified diagnoses that included chronic kidney disease. The Physician's Order Sheet dated 5/1/15, directed outpatient dialysis Tuesday, Thursday and Saturday. R365's care plan dated 5/5/15, directed staff to monitor for potential complications secondary to hemodialysis, check bruit and thrill in left arm every shift, and monitor access site for redness warmth and swelling. The care plan lacked emergency medical interventions and what the facility would do if R365 was unable to receive outpatient dialysis services. On 5/14/15, at 5:07 p.m. licensed practical nurse (LPN)-A was interviewed and stated she was unaware of what to do if R365 was unable to go to outpatient dialysis. On 5/14/15, at 5:42 p.m. registered nurse (RN)-B was interviewed and stated she was unaware of what to do if R365 was unable to go to outpatient dialysis. On 5/14/15, at 6:18 p.m. the director of nursing (DON) was interviewed and verified R365's care	F 309	F309 1. Corrective Action: A. Residents #365 has discharged. 2. Corrective Action as it applies to Other Residents: All patients receiving dialysis have the potential to be affected by this deficient practice. A. The policy and procedure for End-Stage Renal Disease, Care of a Resident with, and The Care Plan Policy has been reviewed and revised and Dialysis Care plan updated to include, refer to the Dialysis information book regarding preparing for emergencies, access catheter care, graft care, diet suggestions which includes emergency medical interventions and what the facility would do if a dialysis patient was unable to receive outpatient dialysis. B. Licensed Nurses will be educated on the policy for End- Stage Renal Disease, Care of a Resident with, and the Care Plan Policy and the Dialysis information book which includes emergency medical interventions and what to do for a dialysis patient who is unable to receive outpatient dialysis which will occur at the nursing meeting on June 16th and June 18th. C. All care plans of patients receiving dialysis were reviewed and revisions were made as appropriate 3. Date of Completion: June 22, 2015.	

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F 309	Continued From page 5 plan lacked directions on what to do if he was unable to go to outpatient dialysis. The facility was unable to provide a policy and procedure on emergency medical interventions for residents receiving outpatient dialysis treatments.	F 309	4. Reoccurrence will be Prevented by: A. Staff education provided on June 16th and June 18th 2015. B. DON or designee will conduct random audits daily for two weeks, then weekly for one month and then monthly for one quarter. Findings will be reported to the QAPI team for review and discussion. 5. The Correction will be Monitored by: A. DON or designee. B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 329		6/22/15

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F 329	Continued From page 6 drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to establish parameters for administration of pain medications for 1 of 5 residents (R67) reviewed for unnecessary medications. Findings include: R67's facesheet included diagnoses of spinal stenosis (narrowing of the the spaces in the spine, causing pressure on the spinal cord), osteoporosis (decreased bone mass and bone strength), rehabilitation procedures and aftercare following surgery. The comprehensive admission minimum data set dated 5/8/15, indicated R67 was cognitively intact and was able to participate in decisions about her daily care. R67's physician orders included: acetaminophen (Tylenol) 650 milligrams (mg) by mouth (po) every 4 hours as needed (prn) pain tramadol (Ultram, a pain medication) 50 mg po every 6 hours prn pain Norco (a pain medication containing hydrocodone and acetaminophen used for pain)10-325 mg; Give 2 tablets po twice daily for pain and give one tablet po every 4 hours prn pain. The physician orders lacked parameters for	F 329	F329 1. Corrective Action: A. Residents #67 has discharged. 2. Corrective Action as it applies to Other Residents: A. The policy and procedure for Administering Pain medications, Pain-Clinical Protocol, Pain Assessment and Management, and pain standing orders has been reviewed and revised as needed to reflect the need to establish parameters for administration of multiple prn pain medications. B. Licensed Nurses will be educated on establishing parameters for administration of multiple prn pain medications by using the 0-10 scale. Education will occur at the nursing meeting on June 16th and June 18th. C. All patients receiving multiple prn pain medications have been evaluated to assure the orders have parameters of when to give one prn medication before another. 3. Date of Completion: June 22, 2015. 4. Reoccurrence will be Prevented by: A. Staff education provided on June 16th and June 18th 2015.	

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F 329	Continued From page 7 determination of which of the three pain medications to use when R67 experienced pain. The care plan initiated 4/28/15, directed nursing to administer analgesic to R67 as per orders. The care plan was silent regarding parameters for administration of pain medications. The April medication administration record (MAR) indicated R67 received the acetaminophen prn on 4/30/15, received the Norco prn on 4/28/15 and 4/29/15, and received the Tramadol prn on 4/30/15. The May MAR indicated R67 received the acetaminophen prn on 5/3/15 and 5/7/15, received the Norco prn on 5/5/15 and 5/9/15, and did not receive the Tramadol. The admission progress note dated 4/28/15, indicated R67 rated pain at 5 out of 10 to her back related to spinal stenosis and indicated the pain increased with movement. The progress note further indicated R67 was using Norco, Ultram, Tylenol, rest and repositioning for pain control. Norco was given at that time. A progress note dated 5/9/15, indicated R67 is receiving Tylenol prn with good relief reported. A progress note dated 5/14/15, indicated R67 is taking scheduled Norco for pain with good relief reported. During an interview on 5/14/15, at 6:11 p.m. R67 stated she asks for pain medications around 3 p.m. R67 stated she feels it when she hasn't gotten her pain medication at that time. R67 stated they have been giving her Tylenol but she preferred the Norco. R67 stated staff do not ask	F 329	B. DON or designee will conduct random audits daily for two weeks, then weekly for one month and then monthly for one quarter. Findings will be reported to the QAPI team for review and discussion. 5. The Correction will be Monitored by: A. DON or designee. B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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F 329	Continued From page 8 her which pain medication she would like. R67 stated she has sometimes asked for the Norco, but has not asked for the Tylenol or the Tramadol. During an interview on 5/14/15, at 12:54 p.m. registered nurse (RN)-D verified there were not parameters to determine which pain medication to use for R67. RN-D stated she would use the pain scale and if R67 rated the pain lower, she would give the Ultram and if R67 rated the pain higher, she would give the Norco. RN-D stated she did not know if R67 would request a specific medication, but stated she knows the Norco because it is scheduled, also. During an interview on 5/14/15, at 1:23 p.m. RN-E stated nursing staff would usually start low and give the Ultram first and then move up to Norco if the Ultram was ineffective. RN-E verified there were no parameters fur use of pain medications for R67. RN-E stated they usually request parameters or clarification on which medication to use for mild pain and which to use for more severe pain, or if the resident is only using one, they will get orders to discontinue the other one. RN-E stated she did not know if R67 would be able to request a specific medication. During an interview on 5/14/15, at 5:59 p.m. the director of nursing (DON) verified there should be parameters for use of prn pain medications. The DON stated patients arrive from the hospital with several pain medications and then the facility needs to get parameters. The facility provided a folder regarding pain management that is given to residents on admission. The resident's pain medication orders are written on the form in the folder. The resident	F 329		

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	245215	A. BUILDING _____ B. WING _____	05/15/2015

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F 329	Continued From page 9 is encouraged to request pain medications prior to treatment in therapy as needed and to notify the nurses if the pain medications are not effective. The facility was unable to provide a policy and procedure for parameters for prn pain medications.	F 329		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure that all staff worn hair restraints, appropriately covering all hair, while in food preparation areas including the kitchen and floor pantries. In addition, the facility failed to allow air flow between full sheet pans while drying. These practices have the potential to affect 56 of 57 residents in the facility. Findings include: During observations on 5/14/15, at 12:29 p.m. three entrances to the facility kitchen were noted to have hairnets available and posted signs	F 371	F371 1. Corrective Action: The following policies have been updated and will continue to be monitored. Drying of Dishes, Pots, Pans and Utensils ¿ Allow air flow between full sheet pans while drying Employee Hair Restraint ¿ Ensure that hair restraints will be worn by all staff, covering all hair while in the food preparation areas including the kitchen, floor pantries & AL dining room.	6/22/15

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F 371	Continued From page 10 stating: "you must have a hair restraint on before entering the kitchen." On 5/14/15, at 4:35 p.m. Dietary Aide (DA)-A entered the facility kitchen without a hair restraint. DA-A had long hair secured into a bun on the crown of her head. DA-A turned around and went back to get a hair restraint, which she placed over her bun only. The remainder of DA-A's hair-front, back and sides-was uncovered. DA-A then walked through the kitchen, into the walk-in cooler, and came out with a half-gallon of milk. DA-A held the half-gallon of milk next to her face, above her shoulder and walked into the back preparation area. In an interview on 5/14/15, at 4:46 p.m., when asked if she typically wears her hairnet that way, DA-A replied, "yes, if it doesn't attach to my bun, then yes". DA-A then adjusted her hair restraint to cover all her hair, did not wash her hands and walked back into the walk-in cooler. During observations on 5/14/15, at 4:46 p.m. in the facility's second floor dining room pantry area, nursing assistant (NA)-A was observed to don a hairnet covering the back of her hair only, leaving the side and bangs uncovered. NA-A exited the pantry area to deliver beverages to the dining room. NA-A returned with the hairnet covering all her hair. As NA-A re-adjusted the hairnet, she stated, "new style" with an uncomfortable laugh. On 5/14/15, at 5:22 p.m., two facility staff entered the kitchen without hair restraints, DA-A and NA-B. They worked in the beverage and dessert area of the kitchen, exiting to the lower level dining rooms.	F 371	2. Corrective Action as it applies to Other Residents: All staff will be required to attend a mandatory in-service to review the ¿Drying of Dishes, Pots, and Pans & Utensils Policy¿ and the ¿Employee Hair Restraint Policy¿ which has been revised to incorporate items related to this survey. The mandatory meetings are scheduled on the following days June 16, 17 & 18 2015 @ 10:00AM & 3:00PM, which all employees will be required to attend. 3. Date of Completion: 6/22/15 4. Reoccurrence will be Prevented by: A. All staff will be required to attend a mandatory in-service to review the ¿Drying of Dishes, Pots, and Pans & Utensils Policy¿ and the ¿Employee Hair Restraint Policy¿ which has been revised to incorporate items related to this survey. The mandatory meetings are scheduled on the following days June 16, 17 & 18 2015 @ 10:00AM & 3:00PM, which all employees will be required to attend. B. Dietary Manager, Executive Chef, the Dietitian or designee will conduct random daily audits for 2 weeks, then weekly for one month and then monthly for one quarter. Findings will be reported to the QAPI team for review and discussion. 5. The Correction will be Monitored by:	

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F 371	Continued From page 11 On 5/14/15, at 6:48 p.m., DA-A was again observed in the beverage/dessert area of the kitchen without any hair restraint. In an interview on 5/14/15, at 5:30 p.m., DM-A stated that all staff in the department are to use a hair restraint. DM-A continued to explain the restraint must cover all hair, including bangs. Men wear hats and the women wear hairnets. DM-A stated staff in other roles in the facility, such as nursing assistants, must abide by this policy when they are preparing food. If staff are behind the line in the kitchen or if they are in a floor's pantry, they are to wear a hair restraint. For staff that are servers, part of their job is to prepare food. Servers are to have their hair up on their head; a ponytail does not suffice. If servers go behind the line, or into a pantry area they need to wear a hair restraint. When in that role, they must wear a hair restraint. DM-A provided the facility policy which stated that hair restraints are required and should cover all hair on the head. The policy also states all staff is required to be wearing a hair restraint when working in the kitchen and the pantry area of the Fountains. During observation on 5/14/15, at 12:29 p.m., full sheet pans were observed nestled together on the drying racks in the clean dish area. There was no room between the pans to allow air flow in order to air dry. In an interview on 5/14/15, at 5:27 p.m., Dietary Manager (DM)-A stated these pans (full sheet or bun pans) are to be alternated-one forward, one back-not nestled in order to air dry. DM-A stated if the pans were nestled, that would be	F 371	A. Dietary Manager, Executive Chef, the Dietitian or designee. B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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F 371	Continued From page 12 unacceptable. The DM-A states he does monitor drying as he walks through the kitchen, but has not documented his efforts. A policy provided specifies that all items must air dry before being put in the proper storage area. The drying racks and the shelves next to them are not the proper storage area for the sheet pans.	F 371		

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	245215	A. BUILDING **02 - NEW REPLACEMENT BLDG** B. WING _____	**05/12/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Lakeshore Inc. was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Health Care Fire Inspections STATE FIRE MARSHAL DIVISION 444 CEDAR ST., SUITE 145 ST. PAUL, MN 55101-514, and By E-Mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION; 1. A description of what has been, or will be, done to correct the deficiency. 2.. The actual, or proposed , completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/09/2015

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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K 000	Continued From page 1 Lakeshore Lutheran Home is a two story building with a full basement, constructed in 2004 and opened in 2005. The construction type is determined to be Type I(443). The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility has a licensed capacity of 60 beds, the census was 55 at the time of inspection.	K 000		
K 144 SS=F	The requirement at 42 CFR, Subpart 483.70(a)) is NOT met by evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on a review of available documentation, it could not be verified that the emergency	K 144	K144	6/26/15

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K 144	Continued From page 2 generator is being properly load tested annually. This deficient practices could affect all residents staff and visitors. Findings include: At the conclusion of the facility tour on 5-12-15 at 10:30 AM, based on interview, and review of the documentation, with Director Facility Maintenance, it could not be determined, if the emergency generator is being tested to ensure that the normal operating temperature of the engine is being reached, or that 30% of name plate rating is being reached, as required by LSC(00) and NFPA 110(99). The last documented full load test was done 14 months ago. The generator is a 300KW, fueled by diesel fuel. This deficient practice was confirmed by the Director of Facility Maintenance (JG) at the time of exit.	K 144	1.Corrective Action: An outside contractor, Zeigler Cat, complete a 4 hour full load test to bring the generator testing back in compliance; the test is scheduled for completion on or before 6/26/2015. Training will be provided, on or before 6/26/15 to maintenance personnel who conduct generator checks on how to properly read the generator information panel. 2. Corrective Action as it applies to Other Residents: A.The facility will schedule a full load test 1 year in advance, to be completed in the next calendar year by qualified personnel to reduce the potential impact on other residents. The scheduling of the load test, 1 year out, will ensure the deficient practice does not reoccur. B. In addition, training of maintenance technicians on how to use the generator information panel to obtain accurate information for recordkeeping purposes will occur on or before 6/26/15. 3.Date of Completion: 6/26/15 4.Reoccurrence will be Prevented by: A. Environmental Service Director or designee will schedule the load test, 1 year out, to ensure the deficient practice does not reoccur. B. In addition, training of maintenance	

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K 144	Continued From page 3	K 144	technicians on how to use the generator information panel to obtain accurate information for recordkeeping purposes will occur on or before 6/26/15. 5.The Correction will be Monitored by: A.Environmental Services Director or designee. B.The QAPI Committee will review the results on a quarterly basis and provide further direction, as needed.	