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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6AYN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00682

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245388**
2.STATE VENDOR OR MEDICAID NO.
(L2) **593043000**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/18/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(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 :
Kathy Hahn, HFE NE II 02/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 02/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/15/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5388

On September 12, 2013 a survey was completed at this facility. The most serious deficiency cited was at a S/S level of F.

On November 18, 2013 a health PCR was completed and determined to be all corrected. But, lack of verification of the life safety code deficiencies warranted a 70day notice and we recommended the following to the CMS RO for imposition and CMS RO concurred:

Mandatory DOPNA, effective December 12, 2013

If DOPNA goes into effect, the facility would be subject to a loss of NATCEP for a two year period beginning December 12, 2013.

On November 23, 2013, a life safety code PCR was completed and verified all tags were corrected. As a result of the most recent revisit, we recommended the following to the CMS RO for imposition and CMS RO concurred:

Mandatory DOPNA, effective December 12, 2013, be rescinded.

Since DOPNA did not go into effect. The facility would not be subject to a two year loss of NATCEP.

See attached CMS-2567B forms from these revisits.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN 24-5388 February 6, 2014

Mr. Michael Corchran, Administrator
Lakeshore Inn Nursing Home
108 8th Street Northwest
Waseca, Minnesota 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 October 22, 2013 the above facility is certified for:

65 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 65 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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5229

November 21, 2013

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

RE: Project Number S5388023

Dear Mr. Corchran:

On October 29, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 12, 2013. 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 November 18, 2013, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 22, 2013. Based on our visit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to our standard survey completed September 12, 2013.

However, compliance with the Life Safety Code (LSC) deficiencies issued pursuant to the September 12, 2013 standard survey has not yet been verified. The most serious LSC deficiencies in your facility at the time of the standard survey were found 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.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 12, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 12, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 12, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Lakeshore Inn Nursing Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 12, 2013. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Post Certification Revisit Form (CMS-2567B) from the November 18, 2013 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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

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 March 12, 2014 (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: 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:

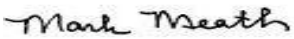
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5388r1_70dayNotice.rtf

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
245388	A. Building B. Wing	11/18/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/22/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **10/22/2013**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **10/22/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **10/22/2013**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **10/22/2013**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **10/22/2013**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **10/22/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **10/22/2013**	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:
	MM/KS	11/21/2013	28591	11/18/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/12/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245388	A. Building / B. Wing: 01 - MAIN BUILDING 01	11/23/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0038	Correction Completed 09/19/2013	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By MM/PS	Date: 02/04/2014	Signature of Surveyor: 25822	Date: 11/23/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 9/10/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

February 4, 2014

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

RE: Project Number F5388021

Dear Mr. Corchran:

On November 21, 2013, we informed you that the following enforcement remedy was being imposed:

> • Mandatory denial of payment for new Medicare and Medicaid admissions, effective December 12, 2013. (42 CFR 488.417 (b))

Also, we notified you in our letter of November 21, 2013, 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 December 12, 2013.

This was based on the deficiencies cited by this Department for a standard survey completed on September 12, 2013, and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our November 21, 2013 notice. The most serious LSC deficiencies in your facility at the time of the standard survey were found 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 November 23, 2013, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 12, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 22, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 12, 2013, as of October 22, 2013.

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 our letter of November 21, 2013. 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 December 12, 2013, 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 December 12, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective December 12, 2013, is to be rescinded.

In our letter of November 21, 2013, we advised you that, 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 December 12, 2013, due to denial of payment for new admissions. Since your facility attained substantial compliance on October 22, 2013, 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 PCR 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5388r270dayAllCorrltr.rtf

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6AYN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00682

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/12/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **65** (L18)

13.Total Certified Beds **65** (L17)

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: B (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	65			
(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 :
Wendy Buckholz, HFE NE II — 11/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 12/12/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed September 12, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7180

October 29, 2013

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

RE: Project Number S5388023

Dear Mr. Corchran:

On September 12, 2013, 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:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - 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:

Kathryn Serie, Unit Supervisor
Mankato District Office
Division of Compliance Monitoring
Licensing and Certification Program
1400 East. Lyon Street.
Marshall, Minnesota 56258

Telephone: (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 [Compliance Due Date()], 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 [Compliance Due Date()] the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

Your PoC must:

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by [Cycle Start + 3 Months()] (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 [Cycle Start + 6 Months()] (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: 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
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245388	A. BUILDING _____ B. WING _____	09/12/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verifcation 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.	F 000	F282 In the spirit of cooperation and consistent with our continuing commitment to an ongoing provision of quality care, R-19's care plan has been updated with the following "encourage resident to clean face after meals and eating snacks in room." "Assist as needed." And "Encourage resident to cover clothing protector for drooling. Provide resident with tissues/towel to wipe face of drool. Monitor for need to change shirt throughout day if wet." R-47's care plan has been updated. Problem has been added "sits with head (face) in hands resulting in red areas on face." Approach has been added, "Monitor face for red areas that do not resolve after an hour without hands on his face. Monitor for bruises." The following has been added to R-49's care plan: "Monitor skin daily	~~11/27~~ 10/22/13
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow the plan of care for 1 of 4 residents (R19) in the sample who required assistance with activities of daily living (including dressing, grooming, and oral hygiene care); and for 2 of 3 residents (R47, R49) in the sample reviewed for non pressure related skin issues/bruising. Findings include: R19 was admitted on 8/13/13 with diagnoses that included: cerebrovascular disease with history of two strokes (CVA), mental deficiency, hypertension and chronic obstructive pulmonary	F 282	approved 11/14/13 KMS	revised with admin approval KMS

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: ADMINISTRATOR | (X6) DATE: 11/12/13

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

RECEIVED
NOV 14 2013
Minnesota Department of Health
Marshall

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F 282	Continued From page 1 disease (COPD). The admission Minimum Data Set (MDS) dated 8/8/13, indicated R19 required extensive assistance of one staff member for personal hygiene. At 3:45 p.m. on 9/9/13, R19 was observed sitting in the common area with food and build up on his lower teeth, food and a white substance dried on his face, and his clothing was stained with food. Later that day at 5:45 p.m., the resident was observed in the dining room wearing the same food stained shirt with dried food on his face. At 9:30 a.m. on 9/11/13, R19 was observed with dried food on his face. At 1:30 p.m. that day, the resident was observed sitting in the common area with food on his shirt and dried food on his face. R19 was also observed to have food and debris on his lower teeth. Review of the resident care plan dated 8/20/13, indicated the resident had a self-care deficit related to CVA and mental deficiency. The plan indicated R19 required supervision and set up for oral care. In addition, the interventions indicated R19 needed extensive assist of one staff member for grooming which included washing his face and dressing. At 9:54 a.m. on 9/12/13, nursing assistant (NA)-B was interviewed and verified the resident required assistance with dressing and set up with brushing his teeth and washing his face. R49 was admitted to the facility 1/2/13 with diagnoses including: memory loss, dementia with behavior disturbance and history of falls at home. During an observation of R49 on 9/9/13 at 3:11 p.m., a dark purple bruise, approximately 2 x 2	F 282	(AM and PM cares) for bruises, skin tears / red areas and report to the nurse." A training memo has been posted in the employee dining room for all employees that it is every department's responsibility to ensure proper grooming of residents. Any employee that sees a resident that is not properly groomed should notify the nurse immediately. All employees have also been informed via a training memo that it is the responsibility of all staff to report signs of injury such as bruises, skin tears and red areas to the nurse immediately. The following statement has been added to the Accident and Supervision Policy and Procedure; "Report any signs of injury (bruises, skin tears or red areas) to the nurse immediately." The revised policy is posted in the employee dining room.	

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F 282	Continued From page 2 centimeter was observed on the resident's right forearm. During the observation, R49 stated that he'd fallen the other day when he was walking with his wife and that's how he'd gotten the bruise. The bruise was present throughout the survey. During an observation of R49 on 9/11/13 at 3:11 p.m. in the dining room, R49 was questioned regarding what happened to his arm. R49 then stated, "oh I fell awhile ago. Then I turned it into a tattoo. It looks like an oak leaf." During medical record review, no documentation was evident to indicate R49 had a bruise on the right forearm. The care plan, dated 3/7/13, identified the problem "potential for impaired skin integrity." The approaches included, "Nurse Aide --- Monitor skin daily with cares and report changes to charge nurse. Keep skin clean and dry." The last documented fall noted in R49's medical record was dated 8/7/13. During interview with the licensed practical nurse A (LPN-A) on 9/11/13 at 2:30 p.m., she stated that documentation was lacking, related to the bruise. LPN-A stated the aides should be checking the skin daily with cares and have been instructed to inform licensed staff if any bruising or any other skin issues were noted. Interview on 9/12/13 at 8:50 a.m. with nursing assistant (NA)-B confirmed she had gotten R49 up this morning but that she had noticed the bruise yesterday (9/11/13). NA-B stated she did not report it as, "I wasn't in that section, I was down on the other end." Interview with the director of nursing (DON) on 9/12/13 at 8:35 a.m., verified that any skin related issues should be reported to the nurse as stated	F 282	The DON or her designee will monitor 10% of the residents for proper grooming. This will be done weekly for 4 weeks, semi-monthly for 2 months, and monthly for 3 months. The DON or her designee will interview staff to determine if they know what they should do if they see a bruise, skin tear or red area on a resident. This will be done weekly for four weeks, twice a month for two months and monthly for three months. The results will be reported and discussed at our quarterly QI meetings.	

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F 282	Continued From page 3 in the care plan. R47 was observed on 9/9, 9/10, and 9/11/13 with a reddish purple area approx. 2 cm (centimeters) in length below the right eye towards the top of the cheekbone. R47's record was reviewed. The plan of care dated 11/5/12 indicated that R47 was at risk for skin breakdown related to limited mobility and cognitive impairment; interventions included, "Monitor skin daily with cares and report changes to charge nurse". When interviewed on 9/10/13 at 1:16 p.m., trained medication aide (TMA)-C stated when discovering a resident with a new skin issue such as a bruise or laceration she would immediately inform the charge nurse of her discovery. TMA-C further stated that if the resident had a known skin condition but felt it had changed, she would also alert the nurse to make sure the nurse was aware of the change in the resident's condition. When interviewed on 9/11/13 at 11:52 a.m., nursing assistant (NA)-A stated that when a new skin condition such as a bruise or skin tear is observed she would notify the nurse right away. When interviewed on 9/11/13 at 3:00 p.m., licensed practical nurse (LPN)-A stated that the bruised area under R47's eye may have been there for awhile but was unsure. LPN-A reviewed R47's chart and was unable to find documentation regarding the area under resident's right eye. LPN-A confirmed that if this was a new skin concern it should have been reported to the nurse and followed up on. LPN-A stated that new/different NA's had been working with R47 lately and may not have known if the	F 282		

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F 282	Continued From page 4 bruise under the right eye was a new skin issue or not. LPN-A verified that regardless it should have been reported and that although the resident was dependent on the staff for cares, no one had reported the bruise to the charge nurse for assessment. When interviewed on 9/11/13 at 3:12 p.m., TMA-B stated she had noticed the bruised area under R47's right eye the day before but hadn't been working the few days prior to that. TMA-B further confirmed that when a new skin issue is observed on a resident it should be reported to the nurse. When interviewed on 9/12/13 at 8:35 a.m., the director of nursing (DON) confirmed that the bruised area under R47's right eye should have been reported and followed up on. The facility's undated policy titled "Pressure Ulcer Policy" was reviewed and included: "Skin is monitored daily by CNA's (certified nursing assistants) and any changes are reported to the nurse".	F 282	In the spirit of cooperation and consistent with our continuing commitment to an ongoing provision of quality care R-47's care plan has been updated. Problem has been added "sits with head (face) in hands resulting in red areas on face." Approach has been added, "Monitor face for red areas that do not resolve after an hour without hands on his face. Monitor for bruises." The following has been added to R-49's care plan: "Monitor skin daily (AM and PM cares) for bruises, skin tears / red areas and report to the nurse."	~~11/27~~ 10/22/13
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. This REQUIREMENT is not met as evidenced	F 309	A training memo has been posted in the employee dining room for all employees that it is every department's responsibility to ensure proper grooming of residents. Any employee that sees a resident that is not properly groomed should	revised with admin approval KMB

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F 309	Continued From page 5 by: Based on observation, interview and document review, the facility failed to provide necessary care and services related to monitoring and prevention of bruises for 2 of 3 residents (R47 and R49) in the sample reviewed for non pressure related skin conditions. Findings include: R49 was admitted to the facility 1/2/13 with diagnoses including: memory loss, dementia with behavior disturbance and history of falls at home. During an observation of R49 on 9/9/13 at 3:11 p.m., a dark purple bruise, approximately 2 x 2 centimeter was observed on the resident's right forearm. During the observation, R49 stated that he'd fallen the other day when he was walking with his wife and that's how he'd gotten the bruise. The bruise was present throughout the survey. During an observation of R49 on 9/11/13 at 3:11 p.m. in the dining room, R49 was questioned regarding what happened to his arm. R49 then stated, "oh I fell awhile ago. Then I turned it into a tattoo. It looks like an oak leaf." During medical record review, no documentation was evident to indicate R49 had a bruise on the right forearm. The care plan, dated 3/7/13, identified the problem "potential for impaired skin integrity." The approaches included, "Nurse Aide --- Monitor skin daily with cares and report changes to charge nurse. Keep skin clean and dry." The last documented fall noted in R49's medical record was dated 8/7/13. During interview with the licensed practical nurse A (LPN-A) on 9/11/13 at 2:30 p.m., she stated	F 309	notify the nurse immediately. All employees have also been informed via a training memo that it is the responsibility of all staff to report signs of injury such as bruises, skin tears and red areas to the nurse immediately. The following statement has been added to the Accident and Supervision Policy and Procedure; "Report any signs of injury (bruises, skin tears or red areas) to the nurse immediately." The revised policy is posted in the employee dining room. The DON or her designee will monitor 10% of the residents for proper grooming. This will be done weekly for 4 weeks, semi-monthly for 2 months, and monthly for 3 months. The DON or her designee will interview staff to determine if they know what they should do if they see a bruise, skin tear or red	

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F 309	Continued From page 6 that documentation was lacking, related to the bruise. LPN-A stated the aides should be checking the skin daily with cares and have been instructed to inform licensed staff if any bruising or any other skin issues were noted. Interview on 9/12/13 at 8:50 a.m. with nursing assistant (NA)-B confirmed she had gotten R49 up this morning but that she had noticed the bruise yesterday (9/11/13). NA-B stated she did not report it as, "I wasn't in that section, I was down on the other end." Interview with the director of nursing (DON) on 9/12/13 at 8:35 a.m., verified that any skin related issues should be reported to the nurse as stated in the care plan During medical record review, no documentation was evident to indicate R49 had a bruise on the right forearm. The care plan, dated 3/7/13, identified the problem "potential for impaired skin integrity." The approaches included, "Nurse Aide --- Monitor skin daily with cares and report changes to charge nurse. Keep skin clean and dry." The last documented fall noted in R49's medical record was dated 8/7/13. During interview with the licensed practical nurse (LPN)-A on 9/11/13 at 2:30 p.m. she confirmed that documentation was missing in the record related to the bruise. She stated the aides should come and report if there was bruising and she would follow-up with the resident to ask what happened. LPN-A stated she would investigate how the bruising could have occurred and would monitor it until resolved. LPN-A also indicated the aides check skin twice a day with cares and	F 309	area on a resident. This will be done weekly for four weeks, twice a month for two months and monthly for three months. The results will be reported and discussed at our quarterly QI meetings.	

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F 309	Continued From page 7 report any abnormalities. She stated, "If they see a bruise they should be letting the nurse know." LPN-A proceeded to interview R49 as to how he got the bruise. R49 told LPN-A that it was a tattoo. LPN-A stated the bruise looked fairly fresh. She also indicated R49 no longer walks anymore. Interview on 9/12/13 at 8:50 a.m. with nursing assistant (NA)-B confirmed she had gotten R49 up this morning but that she had noticed the bruise yesterday (9/11/13). NA-B stated she did not report it as, "I wasn't in that section, I was down on the other end." Interview with the director of nurses (DON) on 9/12/13 at 8:35 a.m. verified that the bruise should have been reported to the nurse. The DON stated she investigated the bruise. She stated that R49 told her he fell and when she asked him when that occurred, R49 replied, "awhile ago." The DON asked R49 where this occurred, R49 stated "oh in some room." The DON indicated that R49's wife told her she thinks R49 picks at his skin. The DON also indicated that R49 wheels independently around the facility and from the location of the bruise, she thinks he may have hit it on the dining room table. R47 was observed on 9/9, 9/10, and 9/11/13 with a reddish purple area approx. 2 cm in length below the right eye towards the top of the cheekbone. Although the resident was dependent on the staff for cares, no one had reported the bruise to the charge nurse for assessment. R47's record was reviewed. R47 was admitted to the facility on 10/24/12. The quarterly minimum	F 309		

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	245388	A. BUILDING _____ B. WING _____	09/12/2013

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F 309	Continued From page 8 data set (MDS) revealed a brief interview for mental status score (BIMS) of 9 indicating moderate cognitive impairment. The plan of care dated 11/5/12 indicated R47 required extensive assistance with one person physical assistance with dressing, grooming, locomotion on and off the unit, and two person physical assistance with transfers and toilet use. The plan of care also revealed that R47 was at risk for skin breakdown related to limited mobility and cognitive impairment. Interventions included, "Monitor skin daily with cares and report changes to charge nurse". When interviewed on 09/10/13 at 1:16 p.m., trained medication aide (TMA)-3 stated when discovering a resident with a new skin issue such as a bruise or laceration she would immediately inform the charge nurse of her discovery. TMA-3 further stated that if the resident had a known skin condition but felt it has changed she would also alert the nurse to make sure the nurse is aware of the change in the resident's condition. When interviewed on 09/11/13 at 11:52 a.m., NA-A stated that when a new skin condition such as a bruise or skin tear is observed she would notify the nurse right away. When interviewed on 09/11/13 at 3:00 p.m., LPN-A stated that the bruised area under R47's eye may have been there for awhile but was unsure. LPN-A reviewed R47's chart and was unable to find documentation regarding the area under resident's right eye. LPN-A confirmed that if this was a new skin concern it should have been reported to the nurse and followed up. LPN-A stated that new/different NA's had been working with R47 lately and may not have known	F 309		

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F 309	Continued From page 9 if the bruise under the right eye was a new skin issue or not. LPN-A verified that regardless it should have been reported. When interviewed on 09/11/13 at 3:12 p.m., TMA-B stated she noticed the bruised area under R47's right eye the day before but hadn't been working the few days prior to that. TMA-B did not remember the bruised area being present prior to that and indicated the bruise was probably something new. TMA-B further confirmed that when a new skin issue is observed on a resident it should be reported to the nurse. When interviewed on 09/12/13 at 8:35 a.m., the DON confirmed that the bruised area under R47's right eye should have been reported and followed up on. The DON investigated the bruising and stated she observed the resident sitting in the dining room with his hands on his face pushing against his cheeks. The DON went on to state the resident had been observed like this often and most likely was the cause of the bruising. The facility's undated policy titled "Pressure Ulcer Policy" was reviewed and included: "Skin is monitored daily by CNA's (certified nursing assistants) and any changes are reported to the nurse".	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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F 312	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with personal hygiene care for 1 of 3 (R19) residents reviewed who were dependent upon staff to maintain grooming and oral hygiene. Findings include: At 3:45 p.m. on 9/9/13, R19 was observed sitting in the common area with food and build up on his lower teeth, food and a white substance dried on his face, and his clothing was stained with food. Later that day at 5:45 p.m., the resident was observed in the dining room wearing the same food stained shirt with dried food on his face. At 9:30 a.m. on 9/11/13, R19 was observed with dried food on his face. At 1:30 p.m. that day, the resident was observed sitting in the common area with food on his shirt and dried food on his face. R19 was also observed to have food and debris on his lower teeth. Record review indicated R19 had been admitted on 8/13/13, with diagnoses that included: cerebrovascular disease with history of two strokes (CVA), mental deficiency, hypertension and chronic obstructive pulmonary disease (COPD). The admission Minimum Data Set (MDS) dated 8/8/13, indicated R19 required extensive assistance of one staff member for personal hygiene. Review of the resident care plan dated 8/20/13, indicated the resident had a self-care deficit related to CVA and mental deficiency. The plan indicated R19 required supervision and set up for oral care. In addition, the interventions indicated	F 312	In the spirit of cooperation and consistent with our continuing commitment to an ongoing provision of quality care R-19's care plan has been updated with the following "encourage resident to clean face after meals and eating snacks in room." "Assist as needed." And "Encourage resident to cover clothing protector for drooling. Provide resident with tissues/towel to wipe face of drool. Monitor for need to change shirt throughout day if wet." The DON or her designee will monitor 10% of the residents for proper grooming. This will be done weekly for 4 weeks, semi-monthly for 2 months, and monthly for 3 months. The DON or her designee will interview staff to determine if they know what they should do if they see a bruise, skin tear or red area on a resident. This will be done weekly for four weeks, twice a month for	~~11/27~~ 10/22/13 Revised with admin approval KMT

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F 312	Continued From page 11 R19 needed extensive assist of one staff member for grooming which included washing his face and dressing. At 9:54 a.m. on 9/12/13, nursing assistant-B was interviewed and verified the resident required assistance with dressing and set up with brushing his teeth and washing his face.	F 312	two months and monthly for three months. The results will be reported and discussed at our quarterly QI meetings.	
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 drugs. This REQUIREMENT is not met as evidenced	F 329	In the spirit of cooperation and consistent with our continuing commitment to an ongoing provision of quality care R-27's PRN pain medications have been reviewed and the Physician has ordered Tramadaol for pain of 6-10 and Tylenol for pain of 1-5. The PRN pain medications of all the residents have been reviewed. If a resident had more than one PRN pain medication, the physician / NP was consulted and if appropriate changed the order to one PRN pain medication. Any resident that has more PRN pain med had parameters set up for each PRN pain medication.	~~11/27~~ 10/22/13 nursed & admin approval KMS

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F 329	Continued From page 12 by: Based on interview and record review, the facility failed to provide parameters for the use of as needed (PRN) Tylenol and Tramadol for 1 of 5 (R27) residents reviewed for unnecessary medication use. Findings include: R27 had physician orders for as needed (PRN) pain medications, Tylenol and Tramadol, without identified parameters for when to use which medication. R27 was admitted on 12/28/09 with a diagnosis that included peripheral neuropathy. Review of the medical record revealed R27 had been admitted to the facility on 12/28/09 with a diagnosis of peripheral neuropathy. The current physician orders dated 12/5/12, included Tramadol 50 miligrams (mg) by mouth every 4 hours as needed (PRN) for pain, and Tylenol 325 mg 2 tablets (650 mg) by mouth every 4 hours PRN for pain. There were no parameters for use identified in the order, nor on the medication administration record, to determine which pain medication (Tylenol vs. Tramadol) should be used to treat R27's pain. Review of the PRN medication sheets from January 1, 2013 through September 4, 2013 revealed the following medication usage: (1) 1/25/12- Tramadol 50 mg given for general discomfort with a pain level of "5"; (2) 3/9/13- Tylenol 325 mg given for pain/discomfort with a pain level of "7"; (3) 3/29/13- Tramadol 50 mg given for pain/discomfort with a pain level of "5";	F 329	The surveyor must have misunderstood LPN – A on 9-11-13 at 2:21 PM. According to LPN A, she stated the TMA consults with the licensed nurse and the licensed nurse would then determine the appropriate medication to administer. According to LPN A, she then stated to surveyor "I would just ask her (R-27) which one she wants, she (R-27) can tell which she wants." The DON or her designee will monitor 10% of the residents with PRN pain medication monthly for 6 months. If a resident has more than one PRN medication, the physician or NP will be consulted for possible discontinuation of the PRN pain medication or add parameters. The results of this monitoring will be reported to the QI committee at their quarterly meeting.	

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F 329	Continued From page 13 (4) 4/15/13 -Tylenol 325 mg given for pain/discomfort with a pain level of "5"; (5) 5/3/13 -Tramadol 50 mg given for lower left back pain with a pain level of "6"; (6) 5/4/13- Tramadol 50 mg given for lower left back pain with a pain level of "5"; (7) 5/5/13 -Tramadol 50 mg given for back pain with a pan level of "4"; (8) 5/7/13- Tramadol 50 mg given for back pain with a pain level of "5"; (9) 5/13/13- Tramadol 50 mg given for back pain with a pain level of "4"; (10) 5/16/13- Tramadol 50 mg given for abdominal pain with a pain level of "5"; (11) 5/25/13- Tramadol 50 mg given for back pain with a pain level of "5"; (12) 7/11/13- Tylenol 325 mg given for headache with a pain level of "7"; (13) 7/27/13- Tylenol 325 mg given for headache with a pain level of "7"; (14) 8/22/13- Tramadol 50 mg given for pain/discomfort with a pain level of "5"; and (15) 9/4/13- Tylenol 325 mg given for headache with a pain level of "5". (Pain level rating scale= 0-10; with 0 rated as no pain and 10 rated as the most severe pain). During interview with licensed practical nurse (LPN)-A on 9/11/13 at 2:21 p.m., she stated the trained medication aide (TMA) consults with the licensed nurse and the licensed nurse would then determine the appropriate medication to administer. LPN-A stated, "I would just ask her [TMA] which one she wants, she [TMA] can tell which she wants to give." R27 stated during interview on 9/12/13 at 9:02 a.m., "I just ask for a pain pill and they give me whatever. I know I have Tylenol. I don't really	F 329		

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F 329	Continued From page 14 know about that other one, that Tramadol. I just ask and they give me one or the other." During an interview with registered nurse (RN)- A on 9/12/13 at 9:57 a.m., it was stated "there are no parameters and there should be. They should be finding out the level of pain and if it's a higher level of pain the Tramadol should be given." During interview with the certified nurse practitioner (CNP) on 9/12/13 at 10:20 a.m., the CNP verified she does not identify parameters for use of pain medication. The CNP stated she should identify parameters so that staff would know which PRN medication to use. She further stated that for a pain level of 1-6, Tylenol could be given, and for a pain level of 7-10 they should be using the Tramadol as it is more severe pain. During interview with the director of nursing (DON) on 9/12/13 at 11:30 a.m., the DON stated she would expect Tylenol to be administered for a headache or general aches/pain, where as the Tramadol would be utilized for higher levels of pain.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed	F 356		

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F 356	Continued From page 15 vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documente review, the facility failed to post the actual hours worked for nursing staff directly responsible for resident care per shift, in a prominent location, readily accessible to residents and the public. This had the potential to affect all 48 residents who resided in the facility. Findings include: During the initial tour on 9/9/13 at 12:10 p.m. the posting of the nurse staffing hours was not visible. During the tour, registered nurse (RN)-A and trained medication aide (TMA)-A confirmed the Report of Nursing Staff document/form for the east/west wing of the facility was located inside	F 356	In the spirit of cooperation and consistent with our continuing commitment to an ongoing provision of quality care we will post hours, by discipline, on both wings. We will post hours on a white board that will be large enough for all to see without asking for the hours. The administrator will spot check to be sure the boards are accurate randomly throughout the month and report the results to the QI committee. The administrator will do this monthly for the first 6 months, and quarterly thereafter for the remainder of one year.	~~11/27~~ 10/27/13 revised c administrator approval xmt

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F 356	Continued From page 16 the nursing office on the east wing; and licensed practical nurse (LPN)-A confirmed that the same document/form for the south wing was located inside the nursing office on the south wing. Immediately following the tour, observation revealed the nurse staffing hours posting was maintained in the nurses' offices on the east/west wing & on the south wing. During observation of the nurse staff posting on 9/9/13 at 1:30 p.m., it was observed that the posting failed to include the exact hours that nursing staff worked each shift by discipline. When interviewed on 9/11/13 at 3:57 p.m., TMA-A confirmed the Report of Nursing Staff document/form was always kept inside the nursing office. TMA-A further confirmed the document/form was not readily accessible to residents or the general public without having to ask for it, and verified she was unaware the posting was supposed to be readily available in a prominent location. When interviewed on 9/12/13 at 9:50 a.m., the chief financial officer and director of nursing (DON), confirmed the staff posting did not include the exact hours that nursing staff worked each shift. The DON also stated the facility has "middle" shifts within the day/evening shifts that were not reflected on the current posting. The DON further confirmed the staff posting had been maintained in the respective nursing offices and was not readily accessible to residents or the general public without having to request to review the posted data.	F 356		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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F 425	Continued From page 17 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their standing orders were clearly written and included dosages and parameters for use. This had the potential to affect 48 of 48 residents currently residing in the facility. Findings include: During review of R27's medication record, an order was noted as follows: "MOM (milk of magnesia) 30 cubic centimeters (cc) qd (daily) PRN (as needed). May decrease to 15 cc if hx (history) of loose stools. May substitute Surfak,	F 425	The facility's revised standing orders have been submitted to the medical director, nurse practitioner and consulting pharmacist for review. Once approved, the revised orders will be relayed to the attending physicians. The attending physician or NP will sign the new standing orders for their residents. The QI committee will be asked for their approval at the QI meeting scheduled for November 26th, 2013. After QI Committee's approval, the standing orders will be updated in the computer. A copy of the standing orders will be posted in each nurse's station. The DON or her designee will monitor 5% of the E-MAR's every month for 3 months to ensure standing orders have dosages and parameters for use. Results of the monitoring will be presented to the QI committee at their quarterly meeting.	~~12/15~~ 10/22/13 revised with admin approval KMS

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F 425	Continued From page 18 Colace, Liquid Colace, Senokot, Ducolax. Do not give to residents with renal insufficiency or renal failure. FOR: Constipation Standing Order." No dosages nor indications were written on the orders for the Surfak, Colace, Liquid Colace, Senokot or Ducolax. During an interview with licensed practical nurse (LPN)-A on 9/11/13, at 2:18 p.m., regarding R27's physician order, LPN-A stated the order had been transcribed from the facility's standing orders. At 2:20 p.m. on 9/11/13, the facility's standing orders were reviewed with LPN-A. Order #4 of the standing orders included: Maalox, Mylanta, Riopan, MOM, Surfak, Liquid Colace, Colace, Senokot, Ducolax tabs, Fruit, Anus or Prep (preparation) HO (for treatment of hemorrhoids) supp (suppository) or cream, Bisocodyl suppositories, Fleets enemas, and/or Soap Suds enemas may be given whenever considered advisable in the opinion of a licensed nurse." There were no dosages or parameters for use identified for any of these medications. LPN-A confirmed that neither dosages nor indications for were listed for these medications on the standing orders. LPN-A then stated, "I think we have a sheet around here someplace that tells what to use." She located a posted form in the medication room entitled, "MEDICATION DOSAGE FOR STANDING ORDERS," which indicated dosages for the various medications including: "Surfak-Docusate calcium, 240 mg, Liquid Colace- Doc Q Lac 100 mg 1 PRN, Peri Colace Docusate sodium 100 mg +30 mg Casanthrol -DocQ Lax, Dulcolax Tabs- 10-15 mg." Senokot was not listed on the posted sheet. In addition, no directions or indications for use were noted on this sheet, and the form was not	F 425		~~11/27~~ 10/22/13 revised c administrators approval kmf

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 19 signed nor dated by a physician. The facility's standing orders were not clearly defined so that staff could administer these medications appropriately. During interview with the certified nurse practitioner (CNP) on 9/12/13 at 10:20 a.m., she verified the standing orders identified were not appropriate as there were no dosages or parameters for use identified. The CNP also stated the medications identified were used to treat different types of issues and included stool softeners, laxatives, etc. During interview with the director of nursing (DON) on 9/12/13 at 11:00 a.m., she stated they have a sheet posted in the nursing stations that included dosages. The DON stated that it was not a good standing order and that an RN (registered nurse) was working on reviewing and setting up new standing orders. The DON stated they are still using the current standing orders until they finish up the other and take it to their quality assurance committee and the medical director for approval. She verified the standing orders identified above were not appropriate as there were no dosages included for the use of the medications, and no parameters identified for when to use what.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 20 nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist identified irregularities in the drug regimen for 1 of 5 residents (R27) in the sample who were reviewed for unnecessary medication. Findings include: R27 had orders for two different as needed (PRN) pain medications, which included Tylenol (an over the counter analgesic) and Tramadol (a prescription narcotic), without identified parameters for when to use which medication. Although the pharmacist had reviewed the resident's medication regime monthly, the pharmacist had not identified the lack of parameters to determine which pain medication to use for R27, as an irregularity. Review of the medical record revealed R27 had been admitted to the facility on 12/28/09 with a diagnosis of peripheral neuropathy. The current physician orders dated 12/5/12, included Tramadol 50 miligrams (mg) by mouth every 4 hours as needed (PRN) for pain, and Tylenol 325 mg 2 tablets (650 mg) by mouth every 4 hours PRN for pain. There were no parameters for use identified in the order, nor on the medication administration record, to determine which pain medication (Tylenol vs. Tramadol) should be used	F 428	In the spirit of cooperation and consistent with our continuing commitment to an ongoing provision of quality care the consulting pharmacist will audit 10% of the residents with PRN pain medication monthly for 6 months. The consulting pharmacist will report any irregularities to the attending physician and director of nursing. The results of this monitoring will be reported to the QI committee at their quarterly meeting.	~~11/27~~ 10/22/13 revised & admin. approved kmt

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F 428	Continued From page 21 to treat R27's pain. Review of the PRN medication sheets from January 1, 2013 through September 4, 2013 indicated the Tylenol and Tramadol were being used inconsistently to manage pain. During interview with licensed practical nurse (LPN)-A on 9/11/13 at 2:21 p.m., she stated the trained medication aide (TMA) consults with the licensed nurse and the licensed nurse would then determine the appropriate medication to administer. LPN-A stated, "I would just ask her [TMA] which one she wants, she [TMA] can tell which she wants to give." R27 stated during interview on 9/12/13 at 9:02 a.m., "I just ask for a pain pill and they give me whatever. I know I have Tylenol. I don't really know about that other one, that Tramadol. I just ask and they give me one or the other." During an interview with registered nurse (RN)- A on 9/12/13 at 9:57 a.m., it was stated "there are no parameters and there should be. They should be finding out the level of pain and if it's a higher level of pain the Tramadol should be given." During interview with the certified nurse practitioner (CNP) on 9/12/13 at 10:20 a.m., the CNP verified she does not identify parameters for use of pain medication. The CNP stated she should identify parameters so that staff would know which PRN medication to use. She further stated that for a pain level of 1-6, Tylenol could be given, and for a pain level of 7-10 they should be using the Tramadol as it is more severe pain. She stated the facility utilized a pain scale of 1-10; with zero (0) rated as no pain and ten (10) rated	F 428		

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F 428	Continued From page 22 as the most severe pain. During interview with the director of nursing (DON) on 9/12/13 at 11:30 a.m., the DON stated she would expect Tylenol to be administered for a headache or general aches/pain, where as the Tramadol would be utilized for higher levels of pain. Interview with the consulting pharmacist on 9/11/13, at 11:30 a.m. verified that there should be parameters identified for the use of the two different pain medications. The consutant pharmacist stated the lack of specific parameters had been missed during his monthly reviews.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must	F 441		

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F 441	Continued From page 23 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a system to track or trend staff illness and/or infections. This has the potential to affect all 48 residents in the facility. Findings include: Review of the facility's infection control surveillance information logs revealed no tracking or trending of staff illness and/or infection was evident . The impact of staff illness/infection had not been tracked related it the impact on the facility's resident population. During interview with the infection control registered nurse (RN)-B on 9/11/13 at 11:00 a.m., she stated that tracking of employee illness or infections had not been done. RN-B stated, "we don't fill slots if they call in. They have to fill their own shifts. We don't keep track of their illnesses.	F 441	In the spirit of cooperation and consistent with our continuing commitment to an ongoing provision of quality care the facility has developed a call in tracking tool. The tool includes the employee's name, date of call in, reason the employee is calling in (illness, family emergency, etc.). If the employee reports an illness, they will be asked if it is infections. If the illness is infectious, (fever, vomiting, diarrhea, open and draining sore), the employee will be reminded of the policy that they cannot report to work with a fever over 101 degrees, vomiting, diarrhea or an open and draining sore. This information will be provided to the infection control nurse who will summarize the information and include it in her quarterly infection control report. Any significant findings will be reported to the QI committee at their quarterly meeting.	~~11/27~~ 10/31/13 revised c admin. approval kmf

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F 441	Continued From page 24 If they have vomiting, temperature or diarrhea they can't be here. If they come in sick we send them home, but we do not keep track of it." An interview with the director of nursing (DON) on 9/12/13, at 11:30 a.m. confirmed the facility had not established a mechanism within their infection control program to track and trend staff illness and/or infection.	F 441		

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	245388	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/10/2013

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K 000	INITIAL COMMENTS FIRE SAFETY 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/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POC ok FB 11-20-13 RECEIVED NOV 14 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC 10-22-13

EXIT: 9-12-13

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

ADMINISTRATOR 11/14/13

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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	245388	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/10/2013**

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

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K 000	Continued From page 1 By email to: Barbara.Lundberg@state.mn.us and 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. Lake Shore Inn Nursing Home is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1960 and was determined to be of Type II(111) construction. In 1968, addition was constructed to the South Wing that was determined to be of Type II(111) construction. In 1984, another addition was added to the South Wing and was determined to be Type II (111). In 1998, an addition was added to the East Wing and was determined to be Type II (111) construction. Because the original building and the 3 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department	K 000		

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K 000	Continued From page 2 notification. The facility has a capacity of 65 beds and had a census of 52 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2., 7.1.6.2 and 7.2.1.4.5. The deficient practice could affect all 26 out 52 residents. Findings include: On facility tour between 8:00 AM and 11:00 AM on 09/10/2013, observation revealed, that the following was found: 1. South exit discharge has a change in elevation of more than 1/2 inch, between concrete sidewalk panels (1 inch) 2. West link exit discharge has a change in elevation of more than 1/2 inch from door thresh hold to concrete sidewalk (3 inch)	K 038	In the spirit of cooperation and consistent with our continuing commitment to an ongoing provision of quality care the facility has brought all entry ways up to code. We backfilled each entry way with compacted sand so that they should not settle as they did the last time. Director of maintenance, or his designee will monitor for settling quarterly for the next year and report findings to the QI committee. 9-19-13	

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K 038	Continued From page 3 These deficient practices were confirmed by the facility Maintenance Director (LR) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 038		