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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8ZVO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00594

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/15/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **60** (L18)
13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:
X 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)
X 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Teresa Ament, Unit Supervisor 09/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/23/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/16/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5215

Lake Shore Inc was not in substantial compliance with Federal participation requirements at the time of the June 30, 2016 survey. On August 15, 2016E the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction. Based on the plan of correction, it has been determined that the facility achieved substantial compliance pursuant to the August 15, 2016 survey, effective August 6, 2016. Refer to the CMS-2567b for health.

Effective August 6, 2016, the facility is certified for 60 skilled nursing facility beds.

Documentation supporting the facility's request for a continuing waiver of the following life safety code deficiencies has previously been forwarded to the CMS Region V Office for their determination:

K0017 42 CFR 483.70(a) NFPA Life Safety Code Standard

K0018 42 CFR 483.70(a) NFPA Life Safety Code Standard

Approval of the waiver requests have been recommended.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245215

September 23, 2016

Mr. Blaine Gamst, Administrator
Lakeshore Inc
4002 London Road
Duluth, Minnesota 55804

Dear Mr. Gamst:

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

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

Effective August 8, 2016 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

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

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K017 and K018.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency(ies) or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 7, 2016

Mr. Blaine Gamst, Administrator
Lakeshore Inc
4002 London Road
Duluth, Minnesota 55804

RE: Project Number S5215028

Dear Mr. Gamst:

On July 18, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 30, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On August 15, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 30, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 8, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 30, 2016, effective August 8, 2016 and therefore remedies outlined in our letter to you dated July 18, 2016, will not be imposed.

Your request for a continuing waiver involving the life safety code deficiencies cited under K017 and K018 at the time of the June 30, 2016 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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

Feel free to contact me if you have questions.

Sincerely,

Mark Meath

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

An equal opportunity employer.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245215 Y1	A. Building B. Wing Y2	8/15/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0242	Correction	ID Prefix F0282	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.15(b)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	08/08/2016	LSC	08/08/2016	LSC	08/08/2016
ID Prefix F0309	Correction	ID Prefix F0314	Correction	ID Prefix	Correction
Reg. # 483.25	Completed	Reg. # 483.25(c)	Completed	Reg. #	Completed
LSC	08/08/2016	LSC	08/08/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒ x	TA/mm	09/06/2016	29433	08/15/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/30/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8ZVO

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/30/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

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

X 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)
X 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B,5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Susan Frericks, HPR SWS — 08/12/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 08/15/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5215

On June 30, 2016, a standard survey was completed at the facility by the Minnesota Departments of Health and Public Safety to determine if the 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 a pattern of deficiencies that constitute no actual, whereby corrections are required. The facility has been given an opportunity to correct before remedies would be imposed. In additiona at the time of the standary survey, an investigation of complaint number H5215039 was conducted and found to be unsubstantiated.

Documentation supporting the facility's request for a continuing waiver of the following life safety code deficiencies have been forwarded to the CMS Region V Office for their determination:

K0017 42 CFR 483.70(a) NFPA Life Safety Code Standard

K0018 42 CFR 483.70(a) NFPA Life Safety Code Standard

Approval of the waiver requests have been recommended.

Refer to the CMS 2567 forms for both health and life safetye code along with the facility's plan of correction, and CMS 2786R Provision Number K84 justification page. Post Certification Revisit (PCR) to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 18, 2016

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

RE: Project Number S5215028, H5215039

Dear Mr. Korzendorfer:

On June 30, 2016, 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. In addition, at the time of the June 30, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5215039. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 30, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5215039 that was found to be unsubstantiated.

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;

Electronic 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:

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Teresa.Ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 9, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 30, 2016 (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 December 30, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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.

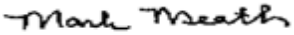
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

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
	245215	A. BUILDING _____ B. WING _____	06/30/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. H Complaint H5215039 was investigated and not substantiated.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 2 of 3 residents (R90, R111) reviewed for dignity. Finding include: R90 stated on 6/27/16, at 10:10 a.m. that on the night shift she was told by staff to just let it (urine) go when she was unable to hold her urine after	F 241	F241 1. Corrective Action: A. Resident□s #R90 and R111 have discharged. 2. Corrective Action as it applies to Other Residents: A. The policy/procedure for Quality of	8/8/16

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

Electronically Signed | 07/26/2016

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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	245215	A. BUILDING _____ B. WING _____	06/30/2016

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F 241	Continued From page 1 putting the call light on waiting a long time for assistance. R90's Admission Record printed on 6/30/16, indicated R90's diagnoses included, a fracture of the right lower leg, a history of falls, severe chronic kidney disease and insomnia. The admission Minimum Data Set (MDS) dated 5/22/16, indicated R90 had moderately impaired cognition. R90 did not have psychosis, behaviors or rejection of cares. R90 was frequently incontinent of urine but was not on a toileting program. R90 needed the assistance of two staff with bed mobility, transfers, ambulation, dressing, toilet use and personal hygiene. The Bowel and Bladder Assessment dated 5/22/16, indicated R90 was frequently incontinent, was alert and orientated and was always aware of the need to use the toilet. A Urinary Incontinence monitoring tool dated 6/1/16 to 6/29/16, indicated R90 was always continent on the day shift, was incontinent one time on the afternoon shift and nine times on the night shift. On 6/27/16, at 10:10 a.m. R90 stated during the night she has had to wait 20-30 minutes for staff to answer her call light. Waiting for staff had caused her to wet the bed. R90 stated when she asked the night staff what she should do when it takes them so long. The staff told her if it gets too uncomfortable, just let it go (be incontinent of urine). R90 stated she felt terrible, cold, wet, uncomfortable and humiliated. On 6/28/16, at 3:40 p.m. R90 stated she had to	F 241	Life-Dignity was reviewed and a Policy and Procedure on Cleaning of Rooms to include cleaning of toilets. B. The Policy and Procedure for Quality of Life-Dignity and Cleaning of Rooms will be reviewed with facility staff on 7/27/16, 7/30/16, 8/1/16, 8/2/16, 8/3/16, 8/4/16, 8/5/16, 8/6/16. 3. Date of Completion: 8/8/16. 4. Reoccurrence will be Prevented by: A. Staff education on The Policy and Procedure for Quality of Life-Dignity and Cleaning of Rooms will be reviewed with facility staff on 7/27/16, 7/30/16, 8/1/16, 8/2/16, 8/3/16, 8/4/16, 8/5/16, 8/6/16, and upon hire, annually, and as needed. B. DON or designee will conduct random audits daily for one month, then weekly for one month and then monthly for one quarter. Findings will be reported to the QAPI team for review and discussion. 5. The Correction will be Monitored by: A. DON or designee. B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

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F 241	Continued From page 2	F 241		

wet the bed a couple times. Prior to coming to the facility she live in an assisted living apartment. While there, at night she got up and went to the bathroom herself and was not incontinent of urine until coming to the facility. R90 stated after she came to the facility they would not let her get up so she had to wait and can no longer use the bedpan. R90 pointed to a sign on the dry erase board that stated no bedpan. R90 stated she did not know why she could not use a bedpan. When she used the bedpan at first it worked fine then the sign appeared and she never had to wet herself when she used the bedpan.

On 6/30/16, at 7:10 a.m. nursing assistant (NA)-A stated R90 was continent of urine with her on the day shift. R90 could put on the call light and was able to tell when she had to urinate. R90 could have possibly been wet when she used the bedpan if it spilled. After awhile when R90 was able, therapy took the bedpan away so she would get up at night like she did when she lived at the assisted living.

On 6/30/16, at 7:40 a.m. the director of nursing (DON) stated staff should not be telling R90 or any resident to be incontinent. Residents should not have to wait that long for the call light to be answered and the facility did not want R90 to be incontinent.

On 6/30/16, at 9:00 a.m. registered nurse (RN)-A verified R90 was continent during the day then was incontinent after about 8:00 p.m. RN-A stated R90 had been using the bedpan at night, then the facility tried the commode at the bedside and then brought R90 to the toilet.

The facility Quality of Life-Dignity policy dated

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F 241	Continued From page 3	F 241		

8/09, directed staff to promote dignity by promptly responding to resident's requests for toileting assistance. A policy on cleaning resident rooms was requested, but not provided by the facility. The daily unit cleaning schedule provided by the facility did not address cleaning resident bathrooms.

R111's Admission Record identified diagnoses that included weakness, amyotrophic lateral sclerosis, type II diabetes mellitus, chronic kidney disease and dependence on renal dialysis.

R111's admission MDS dated 6/17/16, indicated R111 was cognitively intact, exhibited no mood or behavior symptoms, and required extensive assistance with bed mobility, transfers, walking and toileting.

R111's care plan dated 6/22/16, indicated R111 was dependent on staff for meeting physical needs due to decreased mobility.

On 06/28/16, at 8:34 a.m. R111 stated he had to wait twenty minutes for assistance when on the toilet on Saturday, 6/25/16. R111 said he had stool running out and all over the toilet, and his toilet was still dirty from that occurrence. R111 stated he had told nursing staff his toilet was dirty. At 8:45 a.m. R111's toilet was observed to have dark, dried and crusted stool on the top of the bowl and smeared over most of the bottom of the seat with a small amount of dried stool on the top of the seat. At 10:29 a.m. RN-B observed R111's toilet seat and stated it should have been cleaned by housekeeping or nursing staff.

On 6/29/16, at 12:22 p.m. R111 stated he was embarrassed to have visitors see his dirty toilet

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F 241	Continued From page 4 and it was embarrassing to have his toilet dirty for several days. On 6/30/16, at 8:00 a.m. the environmental director (ED) stated bathrooms were cleaned daily and checked more often if the resident had a health problem such as incontinence or diarrhea. On 6/30/16, at 2:17 p.m. the DON stated the resident was known to have loose stools and an afternoon nursing assistant had cleaned the toilet several times in between housekeeping cleanings. The DON stated other nursing assistants should have cleaned the toilet when they noticed this, and she didn't know if other assistants did clean the toilet consistently.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor resident choices for awakening times for 1 of 3 residents (R90) reviewed for choices. Findings include:	F 242	F242 Quality of Life-Self Determination and Participation 1. Corrective Action: A. Resident #R90 has discharged.	8/8/16

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F 242	Continued From page 5 R90's Admission Record printed on 6/30/16, indicated R90's diagnoses included a fracture of the right lower leg, a history of falls, severe chronic kidney disease and insomnia. The admission Minimum Data Set (MDS) dated 5/22/16, indicated R90 had moderately impaired cognition. R90 did not have psychosis, behaviors or rejection of cares. R90 was frequently incontinent of urine but was not on a toileting program. R90 needed the assistance of two staff with bed mobility, transfers, ambulation, dressing, toilet use and personal hygiene. On 6/27/16, at 9:54 a.m. R90 stated staff wake her up about 7:00 a.m. or sometimes a little earlier to take her vitals. R90 stated they tell her she can go back to sleep but then she's wide awake. R90 stated she told someone at the desk but they keep doing it and it had been happening since she came to the facility and it was still going on. R90 stated she had told the nursing assistant (NA) that usually got her up between 7:00 a.m. and 7:30 a.m. that she did not want to get up until 8:00 a.m. R90 stated the NA was pretty firm about getting R90 up. Nice but firm about what the NA had to do. On 6/28/16, at 2:30 p.m. R90 reconfirmed liked to get up at 8:00 a.m. and told staff during the care conference a week or so ago she wanted to stay in bed until 8:00 a.m. R90 stated nothing changed. R90 futher stated even if she wakes up early she liked to stay in bed until 8:00 a.m. because it was nice to know you have time to snuggle in for awhile. On 6/30/16, at 6:54 a.m. NA-B was observed going from room to room obtaining resident vitals.	F 242	2. Corrective Action as it applies to Other Residents: A. The policy/procedure for Quality of Life-Self Determination and Participation was reviewed. B. The Policy and Procedure for Quality of Life-Self Determination and Participation will be reviewed with facility staff on. 7/27/16, 7/30/16, 8/1/16, 8/2/16, 8/3/16, 8/4/16, 8/5/16, and 8/6/16. C. All current residents will be asked what time they would like to get up in the morning, what time would they like to go to bed at night, how often and when they would like a shower, what time they would like their meals, and if they would like a snack and what time to ensure that all residents have the right to choice. 3. Date of Completion: 8/8/16. 4. Reoccurrence will be Prevented by: A. Staff education on The Policy and Procedure for Quality of Life-Self Determination and Participation will be reviewed with facility staff on 7/27/16, 7/30/16, 8/1/16, 8/2/16, 8/3/16, 8/4/16, 8/5/16, and 8/6/16.and upon hire, annually, and as needed. B. All residents will be asked on admission what time they would like to get up in the morning, what time they would like to go to bed at night, how often and when they would like a shower, what time they would like their meals, and if they would like a snack and what time to ensure that all residents have the right to choice.	

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F 242	Continued From page 6 NA-B stated this was the time she usually did the vitals. NA-B did not do a resident's vitals this early if there is not a sign on the door indicating so. R90 did not have a sign on the door. On 6/30/16, at 7:10 a.m. NA-A stated she got R90 up between 7:15 a.m. and 7:20 a.m. NA-A verified R90 had told her she wanted to stay in bed until 8:00 a.m. but that was her schedule at assisted living. The schedule at the facility was to get up early because of therapy. On 6/30/16, at 7:20 a.m. occupational therapist (OT)-A stated she did OT cares with R90 usually around 7:30 a.m. because R90 had falls while trying to get up at the assisted living, was incontinent of urine in the morning and was loosing weight while at the facility so it was important for R90 to get up for breakfast. 8:00 a.m. was the time R90's caregiver arrived and repeatedly told R90 not to get up until 8:00 because she had fallen. On 6/30/16, at 7:40 a.m. the director of nursing (DON) stated R90's request to get up at 8:00 a.m. should have been honored. On 6/30/16, at 9:00 a.m. registered nurse (RN)-A stated she did not have any request from R90 to not be awakened or gotten up until 8:00 a.m. RN-A stated residents were not asked specifically what time they wanted to get up. The facility was unable to provide a policy on resident choices.	F 242	C. DON or designee will conduct random audits daily for one month, then weekly for one month and then monthly for one quarter. Findings will be reported to the QAPI team for review and discussion. 5. The Correction will be Monitored by: A. DON or designee. B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		8/8/16

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F 282	Continued From page 7 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 observation, interview and document review, the facility failed to ensure the care plan was followed for pressure ulcer interventions for 1 of 3 residents (R325) reviewed for pressure ulcers. Findings include: R325's Admission Record printed 6/30/16, indicated R325's diagnoses included after care after surgery of the circulatory system, absence of left foot toes, peripheral vascular disease, type 2 diabetes, polyneuropathy, chronic kidney disease, heart disease and gout. The Skin Care Plan effective 6/7/16, indicated R325 had a suspected deep tissue injury on the right heel. Interventions included turn and reposition when in bed. Reposition when in the chair and offload at least for one minute every hour. The nursing assistant (NA) care guide (not dated) directed staff to turn and reposition R325 when in bed and offload every hour when in the chair. On 6/29/16, R325 was continuously observed from 4:45 p.m. until 6:40 p.m. when the observation ended to inquire about R325's need to be offloaded every hour.	F 282	F282 Services by Qualified Persons/Per Care Plan 1. Corrective Action: A. Resident #R325 has discharged. 2. Corrective Action as it applies to Other Residents: A. The Policy and Procedure for Using the Care Plan and Care Planning-Interdisciplinary Team was reviewed. B. All current residents care plans have been reviewed to ensure that pressure ulcer interventions are in place. Those residents that have pressure ulcers are being audited for timely off-loading, turn and repositioning. C. Licensed Nurses and NA/R□s will be educated on pressure ulcer interventions including off loading and turn and reposition and the group sheets as the plan of care for the resident need to be followed. 3. Date of Completion: 8/8/16. 4. Reoccurrence will be Prevented by: A. Staff education on The Policy and Procedure for Using the Care Plan and	

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F 282	Continued From page 8 At 4:45 p.m. R325 was up in wheelchair in his room. Staff then brought R325 to the dining room. At 6:09 p.m. R325 was brought back to his room by staff and remained sitting up in the wheelchair. Offloading was not provided or offered. At 6:15 p.m. a NA entered R325's room and closed the door. The NA was in the room for approximately 20 seconds. At 6:40 p.m. registered nurse (RN)-A was asked how often R325 was to offload. RN-A stated every hour. At 6:55 p.m. NA-E entered with the stand-aide. NA-E stated she boosted R325 back in the chair by pulling on the back of his pants at approximately 6:20 p.m. but did not stand or offload R325. At 6:58 p.m. R325 stood with the Stand Aid (mechanical lift). R325's buttocks were observed with RN-A. R325's buttocks were not red and did not have any open areas. On 6/29/16, at 6:30 p.m. R325 stated he napped on the bed until he got up for supper. R325 could not remember what time he got up. R325 stated prior to supper and after returning from supper he was not offered or provided repositioning or to be offloaded. On 6/30/16, at 9:00 a.m. the director of nursing (DON) stated she would expect staff to reposition or offload residents as directed by the care plan. The facility was unable to provide a policy on following the care plan.	F 282	Care Planning-Interdisciplinary Team will be reviewed with facility staff on 7/27/16, 7/30/16, 8/1/16, 8/2/16, 8/3/16, 8/4/16, 8/5/16, and 8/6/16.and upon hire, annually, and as needed. B. Licensed Nurses and NA/R□s will be educated on pressure ulcer interventions including off loading, turn and reposition and the group sheets as the plan of care for the resident need to be followed education on 7/27/16, 7/30/16, 8/1/16, 8/2/16, 8/3/16, 8/4/16, 8/5/16, and 8/6/16 C. DON or designee will conduct random audits daily for one month, then weekly for one month and then monthly for one quarter. Findings will be reported to the QAPI team for review and discussion. 5. The Correction will be Monitored by: A. DON or designee. B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	
F 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	F 309		8/8/16

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F 309	Continued From page 9 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 by: Based on interview and document review, the facility failed to ensure a bag lunch was sent to dialysis as ordered for 1 of 1 residents (R111) reviewed for dialysis. Findings include: R111's Admission Record identified diagnoses that included chronic kidney disease and dependence on renal dialysis. R111's admission Minimum Data Set (MDS) dated 6/17/16, indicated R111 was cognitively intact, exhibited no mood or behavior symptoms, and required extensive assistance with bed mobility, transfers, walking and toileting. The MDS further indicated R111 had an active diagnosis of renal insufficiency or end stage renal disease. R111's Order Report dated 6/10/16, directed outpatient dialysis on Mondays, Wednesday, Fridays at 6:30 a.m. The Order Report further directed staff to send a bag lunch with R111 to dialysis on those days. R111's care plan directed staff R111 would be picked up for dialysis at 5:45 a.m. and to send a bag lunch with R111. On 6/29/16, at 12:11 p.m. R111 stated the facility's nursing staff weren't aware of his	F 309	F309 Provide Care/ Services for Highest Well Being 1. Corrective Action: A. Resident #R111 has discharged. 2. Corrective Action as it applies to Other Residents: A. The policy/procedure for End-Stage Renal Disease, Care of a Resident with has been reviewed and revised to include to check Treatment Orders for what meal and when the patient should receive the meal on dialysis days to ensure that all dialysis resident receive their meal. B. The Policy and Procedure for End Stage Renal Disease, Care of a Resident with will be reviewed with Licensed Nurses staff on 7/27/16, 7/30/16, 8/1/16, 8/2/16, 8/3/16, 8/4/16, 8/5/16, and 8/6/16. C. Currently we have no dialysis residents. 3. Date of Completion: 8/8/16. 4. Reoccurrence will be Prevented by: A. Licensed Nurses will be educated on The Policy and Procedure for End-Stage	

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F 309	Continued From page 10 dialysis procedures. R111 further stated the facility staff had never sent a bag lunch with him to dialysis and since no food was sent, he never ate anything while at dialysis. On 6/29/16, nursing assistant (NA)-F stated R111 returned to the facility at 11:00 a.m. after dialysis. NA-F said she wasn't aware of how R111 received a morning meal on those days. On 6/29/16, at 6:14 p.m. registered nurse (RN)-B stated the process for preparing R111 for dialysis was waking R111 and getting him ready. RN-B further stated staff would look in the appointment book and care plan for transportation and meal instructions. RN-B said she was not aware that meals were not sent with R111, and meals should have been sent with him each to dialysis appointment. On 6/30/16, RN-B stated she found the nursing copy of R111's diet order dated 6/10/16. The document was reviewed and included a date of 6/10/16, R111's name and room number and a request for a renal/CCC (consistent carbohydrate diet) and dialysis Monday, Wednesday, Friday at 6:30 a.m. The diet order further directed staff to send a bag lunch for R111 on those days. On 6/30/16, at 9:55 a.m. the food service director (FSD) stated the diet order she had only included a low potassium diet. The FSD also said the diet orders were processed by dietary aide. On 6/30/16, at 9:57 a.m. dietary aide (DA)-A stated she was just been made aware R111 had not been receiving a bag lunch before dialysis. DA-A also said the nursing unit was responsible for ensuring the bag lunch was sent with a	F 309	Renal Disease, Care of a Resident on 7/27/16, 7/30/16, 8/1/16, 8/2/16, 8/3/16, 8/4/16, 8/5/16, and 8/6/16.and upon hire, annually, and as needed. B. On admission the E-TAR and care plan will indicate what meal and when the resident should receive the meal on dialysis days to ensure that all dialysis residents receive their meal. C. DON or designee will conduct random audits daily for one month, then weekly for one month and then monthly for one quarter. Findings will be reported to the QAPI team for review and discussion. 5. The Correction will be Monitored by: A. DON or designee. B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245215	A. BUILDING _____ B. WING _____	06/30/2016

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

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F 309	Continued From page 11 dialysis patient before dialysis. On 6/30/16, at 2:25 p.m. the director of nursing (DON) stated the night nurse said R111 refused the bag lunch one time. The DON further stated there had been no quality assurance done regarding dialysis processes or assurance the care plan for dialysis was followed. The undated facility policy for hemodialysis access care lacked direction on dietary need provisions during a dialysis appointment.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning according to the resident's assessed needs to prevent the development of pressure ulcers for 1 of 3 residents (R325) reviewed for pressure ulcers. Findings include: Pressure Ulcer Stages (defined by the National	F 314	F314 Treatment/Services to Prevent/Heal Pressure Sores 1. Corrective Action: A. Resident #R325 has discharged. 2. Corrective Action as it applies to Other Residents: A. The policy/procedure for Skin	8/8/16

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F 314	Continued From page 12 Pressure Ulcer Advisory Panel) include: Stage I: Non-blanchable erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. R325's Admission Record printed 6/30/16, indicated R325's diagnoses included after care after surgery of the circulatory system, absence of left foot toes, peripheral vascular disease, type 2 diabetes, polyneuropathy, chronic kidney disease, heart disease and gout. A Skin Assessment dated 6/7/16, indicated R325 was at risk for pressure ulcers. R325 had a pressure relieving mattress on the bed and cushion on the wheelchair. R325 had a suspected deep tissue injury to the right heel, blanchable redness on the upper gluteal cleft, a 0.3 centimeter (cm) skin tear, scabbed and flaky skin on the left buttock and multiple areas of blanchable redness on both buttocks. The assessment further indicated staff was to assist with turning and repositioning every two hours and offload (relieve pressure to an area for a minimum of one full minute) every hour.	F 314	Assessment and Care and Care Planning IDT have been reviewed. B. The Policy and Procedure for Skin Assessment and Care and Care Planning IDT will be reviewed with Licensed Nurses, NA/R and Therapy staff on 7/27/16, 7/30/16, 8/1/16, 8/2/16, 8/3/16, 8/4/16, 8/5/16, 8/6/16. C. All current residents care plans and group sheets have been reviewed for pressure ulcer interventions. D. Those residents that currently have pressure ulcers are being audited for off-loading, turn and reposition to ensure the prevention of pressure ulcers. E. Licensed Nurses, NA/R and Therapy staff educated on following the plan of care (group sheets) for residents, definition of off -loading, turn and repositioning to ensure the prevention of pressure ulcers. Date of Completion: 8/8/16 . 3. Reoccurrence will be Prevented by: A. Licensed Nurses, NA/R□s and Therapy staff will be educated on The Policy and Procedure for Skin Assessment and Care and Care Planning IDT on 7/27/16, 7/30/16, 8/1/16, 8/2/16, 8/3/16, 8/4/16, 8/5/16, 8/6/16 and upon hire, annually, and as needed. B. Licensed Nurses, NA/R and Therapy staff educated on following the plan of care (group sheets) for residents, definition of off -loading, turn and repositioning to ensure the prevention of pressure ulcers on 7/27/16, 7/30/16,	

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F 314	Continued From page 13 Skin Assessments dated 6/17/16, and 6/24/16, indicated the upper portion of R325 buttocks had blanchable redness. The skin appeared dry and flaky on the left buttock. The skin tear had healed. An order was received for an adhesive foam type dressing to the sacrum. R325's admission Minimum Data Set (MDS) dated 6/16/16, indicated R325 was cognitively intact, had no behaviors or rejection of cares. R325 needed the extensive assistance of two staff with bed mobility, transfers and toilet use. R325 needed the extensive assistance of one staff with dressing and personal hygiene. R325 did not walk. R325 was at risk for pressure ulcers and had one deep tissue injury. R325 did not have any venous or arterial ulcers. R325 had pressure relieving devices on the bed and in the chair. R325 received pressure ulcer and surgical wound care. The Skin Care Plan effective 6/7/16, indicated R325 had a suspected deep tissue injury on the right heel related to the diagnoses of vascular disease and diabetes. Interventions included turn and reposition when in bed. Reposition when in the chair and offload at least for one minute every hour. The care plan further indicated R325 had an alternating air pressure mattress on the bed and received a barrier cream to the gluteal cleft. The nursing assistant (NA) care guide (not dated) directed staff to turn and reposition R325 when in bed and offload every hour when in the chair. On 6/29/16, R325 was continuously observed from 4:45 p.m. until 6:40 p.m. when the observation ended to inquire about R325's need	F 314	8/1/16, 8/2/16, 8/3/16, 8/4/16, 8/5/16, 8/6/16 and upon hire, annually, and as needed. C. DON or designee will conduct random audits daily for one month, then weekly for one month and then monthly for one quarter. Findings will be reported to the QAPI team for review and discussion. 4. The Correction will be Monitored by: A. DON or designee. B. The QAPI Committee will review the audit results on a quarterly basis and provide further direction, as needed	

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F 314	Continued From page 14	F 314		

to be offloaded every hour.

At 4:45 p.m. R325 was up in wheelchair in his room, staff entered and asked him if he was ready to go down to supper and then brought him to the dining room. At 6:09 p.m. R325 was brought back to his room by staff and remained sitting up in the wheelchair. Offloading was not provided or offered. At 6:15 p.m. a nursing assistant (NA) entered R325's room and closed the door. The NA was in the room for approximately 20 seconds.

At 6:40 p.m. registered nurse (RN)-A was asked how often R325 was to offload. RN-A stated every hour. At 6:45 p.m. RN-A entered R325's room and asked him if he wanted to lay down. R325 stated he was ready to get to bed. RN-A stated she would get his NA. R325 stated he came into the facility with a heart-shaped pressure ulcer on his buttock but was not sure if it was still there. At 6:55 p.m. NA-E entered with the Stand Aid (mechanical lift). NA-E stated she boosted R325 back in the chair by pulling on the back of his pants at approximately 6:20 p.m. but did not stand or offload R325. At 6:58 p.m. R325 stood with the Stand Aid. R325's buttocks were observed with RN-A. R325 had a large adhesive foam type dressing over his coccyx area. RN-A removed the dressing. R325's buttocks were not red and did not have any open areas.

On 6/29/16, at 6:30 p.m. R325 stated he napped on the bed until he got up for supper. R325 could not remember what time he got up. R325 stated prior to supper and after returning from supper he was not offered or provided repositioning or to be offloaded.

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F 314	Continued From page 15 On 6/30/16, at 9:00 a.m. the director of nursing (DON) stated she would expect staff to reposition or offload residents as directed by the care plan. The facility's Skin Assessment and Care policy dated 5/11, indicated each resident would receive the necessary care and services to attain or maintain the highest physical, mental and psychosocial well being in accordance with the comprehensive assessment and care plan related to skin care. A resident who entered the facility without a pressure ulcer would not develop a pressure ulcer unless the resident's clinical condition proved it unavoidable. A resident who currently had a pressure ulcer would receive the necessary treatment and services to promote healing and prevent new pressure ulcers.	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245215	A. BUILDING **02 - NEW REPLACEMENT BLDG** B. WING _____	**06/28/2016**

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

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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 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Lakeshore Inc. was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/26/2016

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

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K 000	Continued From page 1 By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@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 Lakeshore Inc. is a two story building of type II(222) construction that was built in 2004-2005. The building is fully sprinklered and there is supervised smoke detection located in the corridors, space open to corridor and in resident rooms. The facility has 60 certified beds. All beds are certified for Medicare only. At the tie of the inspection the census was 58. The requirement at 42 CFR Subpart 483.70(a) is NOT MET.	K 000		
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is	K 017		7/26/16

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K 017	Continued From page 2 constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility failed to provide corridor walls separations in compliance with NFPA Life Safety Code 101 (00) Sections 18.3.6.1 and 18.3.6.2. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect 40 of 53 residents, as well as an undetermined number of staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM to 1:30 PM on 06/28/2016, observations revealed that the lower level physical therapy and occupational therapy areas were open to the corridor. Patient treatment areas do not meet one of the exceptions for a space allowed to be open to the corridor. This deficient condition was verified by the Maintenance Supervisor.	K 017	Please see attached K084 waiver request form	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be	K 018		7/26/16

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K 018	Continued From page 3 prohibited. 18.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility had multiple corridor doors that did not meet the requirements of NFPA Life Safety Code 101 (2000 edition), section 18.3.6.3.2. This deficient practice could affect 40 of 53 residents, as well as an undetermined number of staff, and visitors of the facility. Findings include: On facility tour between 10:30 AM to 1:30 PM on 06/28/2016, observation revealed that the lower level physical therapy area was open to the corridor and there were two sets of closets with bi-fold doors that were located in the walls around the physical therapy room. Because the physical therapy area is open to the corridor the walls around the physical therapy area must meet the requirements for corridor walls. The doors to the two closets were bi-fold doors that were not automatically positively latching and there was a 1/2" gap at the top of the doors. The doors were not constructed to limit the transfer of smoke and do not meet the requirements for corridor doors. This deficient condition was verified by the Maintenance Supervisor.	K 018	Please see attached K084 waiver request for K018 tag	

245215

Name of Facility 2000 CODE

Lakeshore Inc.; Provider ID No. 245215

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K017, Item 7 Lower level treatment spaces are open to the corridor, which does not comply with NFPA 101(00), Sections 18.3.6.1 and 18.3.6.2.	An annual/continuing waiver is being requested for K017, Item 7. A. Compliance with this provision will cause an unreasonable hardship because: 1. NFPA 101(00), Sec. 4.6.3 allows the authority having jurisdiction to modify the requirements of the Code for existing buildings in cases where their application would be impractical. Lakeshore Inc feels that it would be impractical to separate the physical therapy (PT) and occupational therapy (OT) spaces from the corridor. Lakeshore Inc specializes in the housing and rehabilitation of persons in various stages of recovery from surgery (e.g. hip and knee replacements). Many of these persons use wheelchairs, walkers, canes and/or crutches as they progress through their recovery process. To maintain easy access to the PT and OT spaces, as well as to reduce the potential for injury, these areas were intentionally designed to be as open and barrier free (e.g. doors) as possible. 2. Due to the existence of open grate ceiling tiles in the lower level corridor, any corridor walls constructed must be extended up through the drop ceiling to the floor deck above. This modification would prove exceptionally challenging to bring about due to the supernumerary amount and location of building utilities installed above the drop ceiling (e.g. HVAC ducts, conduits, sewer and water piping, fire sprinkler piping, etc.). 3. Lakeshore Inc feels that the modification necessitated to correct this deficiency would cause the need for inordinate effort, disruption of services and expense with minimal or no gain in life safety. The facility feels that the physical arrangement of the lower level is very similar to that allowed by the Code for suites, based on the following: a. The lower level is roughly 8,750 ft^2 in size, which is less than the 10,000 ft^2 allowed by NFPA 101(00), Sec. 18.2.5.7 for non-sleeping suites. The smoke zone in which the PT/OT spaces are located is roughly 6,070 ft^2 in size. b. There are no sleeping rooms on the lower level. c. There are two exits from the PT/OT space to meet the requirements of NFPA 101(00), Sec. 18.2.5.3. One of these exits discharges directly to the exterior at grade level. (continued on next page)

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date
	FIRE SAFETY SUPERVISOR	STATE FIRE MARSHAL	07-27-2016

Name of Facility 2000 CODE

Lakeshore Inc.; Provider ID No. 245215

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K017, Item 7 Lower level treatment spaces are open to the corridor, which does not comply with NFPA 101(00), Sections 18.3.6.1 and 18.3.6.2.	(continued from previous page) B. There will be no adverse impact on the safety of building occupants due to the following reasons: 1. The lower level is only occupied between the hours of 7:00 AM to 5:00 PM. 2. There are a maximum of 18 residents on the lower level at any given time. Staffing levels are maintained such that a staffing ratio of at least one (1) staff person for each two (2) residents using PT and/or OT services is present. 3. Based on review of building construction drawings and discussion with the facility architect, it has been confirmed that the lower level is subdivided into two separate smoke compartments. 4. The building is protected throughout by a complete supervised automatic fire sprinkler system installed in accordance with NFPA 13. 5. Automatic smoke detection, interconnected with the building's addressable fire alarm system, is present in the corridors and PT/OT spaces open to the corridor on the lower level. 6. The building fire alarm system is monitored to provide automatic notification to the Duluth Fire Department, which is a full-time department. 7. Lakeshore Inc is a smoke-free facility and signs to that effect are prominently displayed at all major entrances to the building.

Surveyor *(Signature)*	Title	Office	Date
Thomas C Smith	FIRE SAFETY SUPERVISOR	STATE FIRE MARSHAL	07-27-2016
Fire Authority Official *(Signature)*	Title	Office	Date

Name of Facility

Lakeshore Inc.; Provider ID No. 245215

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K018, Item 4 Corridor doors do not comply with NFPA 101 (00), Section 18.3.6.3.	A. Compliance with this provision will cause an unreasonable hardship for the following reasons: 1. NFPA 101(00), Sec. 4.6.3 allows the authority having jurisdiction to modify the requirements of the Code for existing buildings in cases where their application would be impractical. Lakeshore Inc feels that it would be impractical to install positive latching doors on the 2 sets of closets with bi-fold doors located in the walls around the physical therapy room as they would restrict access to and interfere with exiting from treatment room #4; in addition, access to and egress from the treatment space located at the southeast corner of the therapy area would be restricted. Lakeshore Inc specializes in the housing and rehabilitation of persons in various stages of recovery from surgery (e.g. hip and knee replacements). Many of these persons use wheelchairs, walkers, canes and/or crutches as they progress through their recovery process. To maintain easy access to the PT spaces, as well as to reduce the potential for injury, these areas were intentionally designed to be as barrier free and open (e.g. doors) as possible. 2. Lakeshore Inc feels that: A. The facility feels that the physical arrangement of the lower level is very similar to that allowed by the Code for suites, based on the following: the storage areas are less than 50 ft2 (North closet is 22.5ft^2 and South closet is 21ft^2). Both of these areas are fully sprinklered. 18.3.6.1 exception #1 spaces are allowed to be open to the corridor provided certain criteria are met. B. The correction of this deficiency would cause the need for disproportionate effort, expense and disruption of services with minimal or no increase in life safety. a. There are no sleeping rooms on the lower level. b. The lower level is roughly 8,750 ft^2 in size, which is less than the 10,000 ft^2 allowed by NFPA 101(00), Sec. 18.2.5.7 for non-sleeping suites. The smoke zone in which the PT/OT spaces are located is roughly 6,070 ft^2 in size. c. There are two exits from the PT/OT space to meet the requirements of NFPA 101(00), Sec. 18.2.5.3. One of these exits discharges directly to the exterior at grade level. (continued on next page)

Surveyor *(Signature)*	Title	Office	Date

Fire Authority Official *(Signature)*	Title	Office	Date
T. Allen Lamb	FIRE SAFETY SUPERVISOR	STATE FIRE MARSHAL	07-27-2016

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K018, Item 4 Corridor doors do not comply with NFPA 101 (00), Section 18.3.6.3.	(continued from previous page) 3. There will be no adverse effect on the safety of building occupants because: 1. The lower level is only occupied between the hours of 7:00 AM to 5:00 PM. 2. There are a maximum of 18 residents on the lower level at any time. Sufficient staff are present to maintain a staffing ratio of at least one (1) staff person for each two (2) residents using PT and/or OT services. 3. Based on review of building construction drawings and discussion with the facility architect, it has been confirmed that the lower level is subdivided into two separate smoke compartments. 4. The building is protected throughout by a complete supervised automatic fire sprinkler system installed in accordance with NFPA 13. 5. Automatic smoke detection, interconnected with the building's addressable fire alarm system, is present in the corridors and PT/OT spaces open to the corridor on the lower level. 6. The building fire alarm system is monitored to provide automatic notification to the Duluth Fire Department, which is a full-time department. 7. Lakeshore Inc is a smoke-free facility and signs to that effect are prominently displayed at all major entrances to the building.

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title FIRE SAFETY SUPERVISOR	Office STATE FIRE MARSHAL	Date 07-27-2016

Electronically delivered
July 18, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5215028, H5215039

Dear Mr. Korzendorfer:

The above facility was surveyed on June 27, 2016 through June 30, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5215039. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Teresa Ament at (218) 302-6151 or email: teresa@ament@state.mn.us**.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00594	A. BUILDING: _____ B. WING _____	06/30/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 6/27/16 through 6/30/16, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. H Complaint H5215039 was investigated and not substantiated. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed for pressure ulcer interventions for 1 of 3 residents (R325) reviewed for pressure ulcers. Findings include: R325's Admission Record printed 6/30/16, indicated R325's diagnoses included after care after surgery of the circulatory system, absence of left foot toes, peripheral vascular disease, type 2 diabetes, polyneuropathy, chronic kidney disease, heart disease and gout. The Skin Care Plan effective 6/7/16, indicated R325 had a suspected deep tissue injury on the right heel. Interventions included turn and reposition when in bed. Reposition when in the chair and offload at least for one minute every	2 565	Corrected.	8/8/16

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2 565	Continued From page 3 hour. The nursing assistant (NA) care guide (not dated) directed staff to turn and reposition R325 when in bed and offload every hour when in the chair. On 6/29/16, R325 was continuously observed from 4:45 p.m. until 6:40 p.m. when the observation ended to inquire about R325's need to be offloaded every hour. At 4:45 p.m. R325 was up in wheelchair in his room. Staff then brought R325 to the dining room. At 6:09 p.m. R325 was brought back to his room by staff and remained sitting up in the wheelchair. Offloading was not provided or offered. At 6:15 p.m. a NA entered R325's room and closed the door. The NA was in the room for approximately 20 seconds. At 6:40 p.m. registered nurse (RN)-A was asked how often R325 was to offload. RN-A stated every hour. At 6:55 p.m. NA-E entered with the stand-aide. NA-E stated she boosted R325 back in the chair by pulling on the back of his pants at approximately 6:20 p.m. but did not stand or offload R325. At 6:58 p.m. R325 stood with the Stand Aid (mechanical lift). R325's buttocks were observed with RN-A. R325's buttocks were not red and did not have any open areas. On 6/29/16, at 6:30 p.m. R325 stated he napped on the bed until he got up for supper. R325 could not remember what time he got up. R325 stated prior to supper and after returning from supper he was not offered or provided repositioning or to be offloaded. On 6/30/16, at 9:00 a.m. the director of nursing (DON) stated she would expect staff to reposition	2 565		

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2 565	Continued From page 4 or offload residents as directed by the care plan. The facility was unable to provide a policy on following the care plan. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure care plans are followed for all residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced	2 830		8/8/16

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2 830	Continued From page 5 by: Based on interview and document review, the facility failed to ensure a bag lunch was sent to dialysis as ordered for 1 of 1 residents (R111) reviewed for dialysis. Findings include: R111's Admission Record identified diagnoses that included chronic kidney disease and dependence on renal dialysis. R111's admission Minimum Data Set (MDS) dated 6/17/16, indicated R111 was cognitively intact, exhibited no mood or behavior symptoms, and required extensive assistance with bed mobility, transfers, walking and toileting. The MDS further indicated R111 had an active diagnosis of renal insufficiency or end stage renal disease. R111's Order Report dated 6/10/16, directed outpatient dialysis on Mondays, Wednesday, Fridays at 6:30 a.m. The Order Report further directed staff to send a bag lunch with R111 to dialysis on those days. R111's care plan directed staff R111 would be picked up for dialysis at 5:45 a.m. and to send a bag lunch with R111. On 6/29/16, at 12:11 p.m. R111 stated the facility's nursing staff weren't aware of his dialysis procedures. R111 further stated the facility staff had never sent a bag lunch with him to dialysis and since no food was sent, he never ate anything while at dialysis. On 6/29/16, nursing assistant (NA)-F stated R111 returned to the facility at 11:00 a.m. after dialysis. NA-F said she wasn't aware of how R111 received a morning meal on those days.	2 830	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 6 On 6/29/16, at 6:14 p.m. registered nurse (RN)-B stated the process for preparing R111 for dialysis was waking R111 and getting him ready. RN-B further stated staff would look in the appointment book and care plan for transportation and meal instructions. RN-B said she was not aware that meals were not sent with R111, and meals should have been sent with him each to dialysis appointment. On 6/30/16, RN-B stated she found the nursing copy of R111's diet order dated 6/10/16. The document was reviewed and included a date of 6/10/16, R111's name and room number and a request for a renal/CCC (consistent carbohydrate diet) and dialysis Monday, Wednesday, Friday at 6:30 a.m. The diet order further directed staff to send a bag lunch for R111 on those days. On 6/30/16, at 9:55 a.m. the food service director (FSD) stated the diet order she had only included a low potassium diet. The FSD also said the diet orders were processed by dietary aide. On 6/30/16, at 9:57 a.m. dietary aide (DA)-A stated she was just been made aware R111 had not been receiving a bag lunch before dialysis. DA-A also said the nursing unit was responsible for ensuring the bag lunch was sent with a dialysis patient before dialysis. On 6/30/16, at 2:25 p.m. the director of nursing (DON) stated the night nurse said R111 refused the bag lunch one time. The DON further stated there had been no quality assurance done regarding dialysis processes or assurance the care plan for dialysis was followed. The undated facility policy for hemodialysis	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 7 access care lacked direction on dietary need provisions during a dialysis appointment. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could review and revise policies and procedures for ensuring meals are provided for residents who require dialysis. Staff could be educated as necessary. The director of nursing or designee could monitor on a regular basis to ensure continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by:	2 900		8/8/16

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2 900	Continued From page 8 Based on observation, interview and document review, the facility failed to provide timely repositioning according to the resident's assessed needs to prevent the development of pressure ulcers for 1 of 3 residents (R325) reviewed for pressure ulcers. Findings include: Pressure Ulcer Stages (defined by the National Pressure Ulcer Advisory Panel) include: Stage I: Non-blanchable erythema Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The area may be painful, firm, soft, warmer or cooler as compared to adjacent tissue. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. R325's Admission Record printed 6/30/16, indicated R325's diagnoses included after care after surgery of the circulatory system, absence of left foot toes, peripheral vascular disease, type 2 diabetes, polyneuropathy, chronic kidney disease, heart disease and gout. A Skin Assessment dated 6/7/16, indicated R325 was at risk for pressure ulcers. R325 had a pressure relieving mattress on the bed and cushion on the wheelchair. R325 had a	2 900	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 900	Continued From page 9 suspected deep tissue injury to the right heel, blanchable redness on the upper gluteal cleft, a 0.3 centimeter (cm) skin tear, scabbed and flaky skin on the left buttock and multiple areas of blanchable redness on both buttocks. The assessment further indicated staff was to assist with turning and repositioning every two hours and offload (relieve pressure to an area for a minimum of one full minute) every hour. Skin Assessments dated 6/17/16, and 6/24/16, indicated the upper portion of R325 buttocks had blanchable redness. The skin appeared dry and flaky on the left buttock. The skin tear had healed. An order was received for an adhesive foam type dressing to the sacrum. R325's admission Minimum Data Set (MDS) dated 6/16/16, indicated R325 was cognitively intact, had no behaviors or rejection of cares. R325 needed the extensive assistance of two staff with bed mobility, transfers and toilet use. R325 needed the extensive assistance of one staff with dressing and personal hygiene. R325 did not walk. R325 was at risk for pressure ulcers and had one deep tissue injury. R325 did not have any venous or arterial ulcers. R325 had pressure relieving devices on the bed and in the chair. R325 received pressure ulcer and surgical wound care. The Skin Care Plan effective 6/7/16, indicated R325 had a suspected deep tissue injury on the right heel related to the diagnoses of vascular disease and diabetes. Interventions included turn and reposition when in bed. Reposition when in the chair and offload at least for one minute every hour. The care plan further indicated R325 had an alternating air pressure mattress on the bed and received a barrier cream to the gluteal cleft.	2 900		

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2 900	Continued From page 10 The nursing assistant (NA) care guide (not dated) directed staff to turn and reposition R325 when in bed and offload every hour when in the chair. On 6/29/16, R325 was continuously observed from 4:45 p.m. until 6:40 p.m. when the observation ended to inquire about R325's need to be offloaded every hour. At 4:45 p.m. R325 was up in wheelchair in his room, staff entered and asked him if he was ready to go down to supper and then brought him to the dining room. At 6:09 p.m. R325 was brought back to his room by staff and remained sitting up in the wheelchair. Offloading was not provided or offered. At 6:15 p.m. a nursing assistant (NA) entered R325's room and closed the door. The NA was in the room for approximately 20 seconds. At 6:40 p.m. registered nurse (RN)-A was asked how often R325 was to offload. RN-A stated every hour. At 6:45 p.m. RN-A entered R325's room and asked him if he wanted to lay down. R325 stated he was ready to get to bed. RN-A stated she would get his NA. R325 stated he came into the facility with a heart-shaped pressure ulcer on his buttock but was not sure if it was still there. At 6:55 p.m. NA-E entered with the Stand Aid (mechanical lift). NA-E stated she boosted R325 back in the chair by pulling on the back of his pants at approximately 6:20 p.m. but did not stand or offload R325. At 6:58 p.m. R325 stood with the Stand Aid. R325's buttocks were observed with RN-A. R325 had a large adhesive foam type dressing over his coccyx area. RN-A removed the dressing. R325's buttocks were not red and did not have any open areas.	2 900		

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	00594	A. BUILDING: _____ B. WING _____	06/30/2016

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2 900	Continued From page 11 On 6/29/16, at 6:30 p.m. R325 stated he napped on the bed until he got up for supper. R325 could not remember what time he got up. R325 stated prior to supper and after returning from supper he was not offered or provided repositioning or to be offloaded. On 6/30/16, at 9:00 a.m. the director of nursing (DON) stated she would expect staff to reposition or offload residents as directed by the care plan. The facility's Skin Assessment and Care policy dated 5/11, indicated each resident would receive the necessary care and services to attain or maintain the highest physical, mental and psychosocial well being in accordance with the comprehensive assessment and care plan related to skin care. A resident who entered the facility without a pressure ulcer would not develop a pressure ulcer unless the resident's clinical condition proved it unavoidable. A resident who currently had a pressure ulcer would receive the necessary treatment and services to promote healing and prevent new pressure ulcers. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents do not develop a pressure ulcer unless it is clinically unavoidable, and residents who do have pressure ulcers are receiving the proper care and services needed to promote healing, prevent infection and promote new pressure ulcers from developing. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.	2 900		

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2 900	Continued From page 12 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained for 2 of 3 residents (R90, R111) reviewed for dignity. Finding include: R90 stated on 6/27/16, at 10:10 a.m. that on the night shift she was told by staff to just let it (urine) go when she was unable to hold her urine after putting the call light on waiting a long time for assistance. R90's Admission Record printed on 6/30/16, indicated R90's diagnoses included, a fracture of the right lower leg, a history of falls, severe chronic kidney disease and insomnia. The admission Minimum Data Set (MDS) dated 5/22/16, indicated R90 had moderately impaired cognition. R90 did not have psychosis, behaviors or rejection of cares. R90 was frequently incontinent of urine but was not on a toileting	21805	Corrected.	8/8/16

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21805	Continued From page 13	21805		

program. R90 needed the assistance of two staff with bed mobility, transfers, ambulation, dressing, toilet use and personal hygiene.

The Bowel and Bladder Assessment dated 5/22/16, indicated R90 was frequently incontinent, was alert and orientated and was always aware of the need to use the toilet.

A Urinary Incontinence monitoring tool dated 6/1/16 to 6/29/16, indicated R90 was always continent on the day shift, was incontinent one time on the afternoon shift and nine times on the night shift.

On 6/27/16, at 10:10 a.m. R90 stated during the night she has had to wait 20-30 minutes for staff to answer her call light. Waiting for staff had caused her to wet the bed. R90 stated when she asked the night staff what she should do when it takes them so long. The staff told her if it gets too uncomfortable, just let it go (be incontinent of urine). R90 stated she felt terrible, cold, wet, uncomfortable and humiliated.

On 6/28/16, at 3:40 p.m. R90 stated she had to wet the bed a couple times. Prior to coming to the facility she live in an assisted living apartment. While there, at night she got up and went to the bathroom herself and was not incontinent of urine until coming to the facility. R90 stated after she came to the facility they would not let her get up so she had to wait and can no longer use the bedpan. R90 pointed to a sign on the dry erase board that stated no bedpan. R90 stated she did not know why she could not use a bedpan. When she used the bedpan at first it worked fine then the sign appeared and she never had to wet herself when she used the bedpan.

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21805	Continued From page 14 On 6/30/16, at 7:10 a.m. nursing assistant (NA)-A stated R90 was continent of urine with her on the day shift. R90 could put on the call light and was able to tell when she had to urinate. R90 could have possibly been wet when she used the bedpan if it spilled. After awhile when R90 was able, therapy took the bedpan away so she would get up at night like she did when she lived at the assisted living. On 6/30/16, at 7:40 a.m. the director of nursing (DON) stated staff should not be telling R90 or any resident to be incontinent. Residents should not have to wait that long for the call light to be answered and the facility did not want R90 to be incontinent. On 6/30/16, at 9:00 a.m. registered nurse (RN)-A verified R90 was continent during the day then was incontinent after about 8:00 p.m. RN-A stated R90 had been using the bedpan at night, then the facility tried the commode at the bedside and then brought R90 to the toilet. R111's Admission Record identified diagnoses that included weakness, amyotrophic lateral sclerosis, type II diabetes mellitus, chronic kidney disease and dependence on renal dialysis. R111's admission MDS dated 6/17/16, indicated R111 was cognitively intact, exhibited no mood or behavior symptoms, and required extensive assistance with bed mobility, transfers, walking and toileting. R111's care plan dated 6/22/16, indicated R111 was dependent on staff for meeting physical needs due to decreased mobility. On 06/28/16, at 8:34 a.m. R111 stated he had to	21805		

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21805	Continued From page 15 wait twenty minutes for assistance when on the toilet on Saturday, 6/25/16. R111 said he had stool running out and all over the toilet, and his toilet was still dirty from that occurrence. R111 stated he had told nursing staff his toilet was dirty. At 8:45 a.m. R111's toilet was observed to have dark, dried and crusted stool on the top of the bowl and smeared over most of the bottom of the seat with a small amount of dried stool on the top of the seat. At 10:29 a.m. RN-B observed R111's toilet seat and stated it should have been cleaned by housekeeping or nursing staff. On 6/29/16, at 12:22 p.m. R111 stated he was embarrassed to have visitors see his dirty toilet and it was embarrassing to have his toilet dirty for several days. On 6/30/16, at 8:00 a.m. the environmental director (ED) stated bathrooms were cleaned daily and checked more often if the resident had a health problem such as incontinence or diarrhea. On 6/30/16, at 2:17 p.m. the DON stated the resident was known to have loose stools and an afternoon nursing assistant had cleaned the toilet several times in between housekeeping cleanings. The DON stated other nursing assistants should have cleaned the toilet when they noticed this, and she didn't know if other assistants did clean the toilet consistently. The facility Quality of Life-Dignity policy dated 8/09, directed staff to promote dignity by promptly responding to resident's requests for toileting assistance. A policy on cleaning resident rooms was requested, but not provided by the facility. The daily unit cleaning schedule provided by the facility did not address cleaning resident	21805		

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21805	Continued From page 16 bathrooms. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's dignity is maintained and toilets are cleaned in a timely manner. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify	21830		8/8/16

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21830	Continued From page 17	21830		

either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the

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21830	Continued From page 18 patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to honor resident choices for awakening times for 1 of 3 residents (R90) reviewed for choices. Findings include: R90's Admission Record printed on 6/30/16, indicated R90's diagnoses included a fracture of	21830	Corrected.	

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21830	Continued From page 19 the right lower leg, a history of falls, severe chronic kidney disease and insomnia. The admission Minimum Data Set (MDS) dated 5/22/16, indicated R90 had moderately impaired cognition. R90 did not have psychosis, behaviors or rejection of cares. R90 was frequently incontinent of urine but was not on a toileting program. R90 needed the assistance of two staff with bed mobility, transfers, ambulation, dressing, toilet use and personal hygiene. On 6/27/16, at 9:54 a.m. R90 stated staff wake her up about 7:00 a.m. or sometimes a little earlier to take her vitals. R90 stated they tell her she can go back to sleep but then she's wide awake. R90 stated she told someone at the desk but they keep doing it and it had been happening since she came to the facility and it was still going on. R90 stated she had told the nursing assistant (NA) that usually got her up between 7:00 a.m. and 7:30 a.m. that she did not want to get up until 8:00 a.m. R90 stated the NA was pretty firm about getting R90 up. Nice but firm about what the NA had to do. On 6/28/16, at 2:30 p.m. R90 reconfirmed liked to get up at 8:00 a.m. and told staff during the care conference a week or so ago she wanted to stay in bed until 8:00 a.m. R90 stated nothing changed. R90 futher stated even if she wakes up early she liked to stay in bed until 8:00 a.m. because it was nice to know you have time to snuggle in for awhile. On 6/30/16, at 6:54 a.m. NA-B was observed going from room to room obtaining resident vitals. NA-B stated this was the time she usually did the vitals. NA-B did not do a resident's vitals this early if there is not a sign on the door indicating so.	21830		

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21830	Continued From page 20 R90 did not have a sign on the door. On 6/30/16, at 7:10 a.m. NA-A stated she got R90 up between 7:15 a.m. and 7:20 a.m. NA-A verified R90 had told her she wanted to stay in bed until 8:00 a.m. but that was her schedule at assisted living. The schedule at the facility was to get up early because of therapy. On 6/30/16, at 7:20 a.m. occupational therapist (OT)-A stated she did OT cares with R90 usually around 7:30 a.m. because R90 had falls while trying to get up at the assisted living, was incontinent of urine in the morning and was loosing weight while at the facility so it was important for R90 to get up for breakfast. 8:00 a.m. was the time R90's caregiver arrived and repeatedly told R90 not to get up until 8:00 because she had fallen. On 6/30/16, at 7:40 a.m. the director of nursing (DON) stated R90's request to get up at 8:00 a.m. should have been honored. On 6/30/16, at 9:00 a.m. registered nurse (RN)-A stated she did not have any request from R90 to not be awakened or gotten up until 8:00 a.m. RN-A stated residents were not asked specifically what time they wanted to get up. The facility was unable to provide a policy on resident choices. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents are given choices with their daily routines. The Director of Nursing or designee could educate all appropriate staff on the policies and	21830		

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21830	Continued From page 21 procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) Days	21830		