DEPARTMENT OF HEALT			D CEDTIEI		CENTERS FOR MEE AND TRANSMITTAL	DICARE & MEDICAID SERVICES
	-		-		TE SURVEY AGENCY	ID: 8ZVO Facility ID: 00594
I. MEDICARE/MEDICAID PROVIDI           (L1)         245215           2.STATE VENDOR OR MEDICAID N           (L2)         001043000		3. NAME AND AI (L3) <b>LAKESHOI</b> (L4) <b>4002 LOND</b> (L5) <b>DULUTH, N</b>	RE INC ON ROAD	CILITY	(L6) <b>55804</b>	4. TYPE OF ACTION:       7 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint
<ol> <li>5. EFFECTIVE DATE CHANGE OF (L9)</li> <li>6. DATE OF SURVEY 08/15</li> <li>8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other</li> </ol>	OWNERSHIP 5/2016 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	JPPLIER CATEG 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	ORY 09 ESRD 10 NF 11 ICF/IID 12 RHC	<u>02</u> (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 06/30
11LTC PERIOD OF CERTIFICATION         From       (a) :         To       (b) :         12.Total Facility Beds         13.Total Certified Beds	N 60 (L18) 60 (L17)	Complianc			And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN X 5. Life Safety Code	6. Scope of Services Limit 7. Medical Director
		Requirements	and/or Applied V	Vaivers:	* Code: A,5	(L12)
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 60	JWN 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM     See Attached Remarks     17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Teresa Ament, Unit Supe			09/07/2016	(L19)	Mark Meath	(L20)
PA	RT II - TO BE				OFFICE OR SINGLE S	TATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBII</li> <li><u>X</u></li> <li>1. Facility is Eligible to F</li> <li><u>2</u>. Facility is not Eligible</li> </ol>	Participate		IPLIANCE WITH HTS ACT:	I CIVIL		acial Solvency (HCFA-2572) l Interest Disclosure Stmt (HCFA-1513) : 
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	IENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION <b>07/01/1977</b>	BEGINNINC	<b>DATE</b>	ENDING DA	ГЕ	VOLUNTARY     00       01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse 03-Risk of Involuntary Terminatio	0
25. LTC EXTENSION DATE: (L27)		n of Admissions:	(L44)		04-Other Reason for Withdrawal	07-Provider Status Change 00-Active
(L27)	B. Rescind Su	spension Date:	(1.45)			
28. TERMINATION DATE:	20	. INTERMEDIARY	(L45)		30. REMARKS	
20. TERMINATION DATE.	29	03001	CARAIER NO.		55. REMERKS	
	(L28)	05001		(L31)		
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	I OF APPROVAL	DATE		
	(L32)	08/16/2016		(L33)	DETERMINATION APPE	ROVAL

# 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

#### 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.



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.

Lakeshore Inc September 23, 2016 Page 2

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

Sincerely,

# Mark Weath

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



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

# **POST-CERTIFICATION REVISIT REPORT**

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		Γ	DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
245215 <sub>Y1</sub>	B. Wing	Y2	2 8	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	DATE	ITEM	DATE	ITEM		DATE
Y4	Y5	Y4	Y5	Y4		Y5
ID Prefix F0241	Correction	ID Prefix F0242	Correction	ID Prefix	F0282	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.15	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
483.25 Reg. #	Completed	Reg. # 483.25	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		
REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS) TA/mm	DATE 09/06/2016	SIGNATURE OF SURVEYOR	9433	DATE	08/15/2016
REVIEWED BY CMS RO	REVIEWED BY (INITIALS)	DATE	TITLE		DATE	
FOLLOWUP TO SURVE	Y COMPLETED ON		R ANY UNCORRECTED DEFICIEI CTED DEFICIENCIES (CMS-2567)	NCIES. WAS SENT TO TH		s 🗌 no

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

-

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

	MEDICARE/MEDICAID CERTIFICAT PART I - TO BE COMPLETED BY THE							
MEDICARE/MEDICAID PROVIDER N     (L1) 245215     2.STATE VENDOR OR MEDICAID NO.     (L2) 001043000     5. EFFECTIVE DATE CHANGE OF OWN     (L9)		<ol> <li>NAME AND ADI</li> <li>(L3) LAKESHOR</li> <li>(L4) 4002 LONDO</li> <li>(L5) DULUTH, M</li> <li>PROVIDER/SUP</li> <li>01 Hospital</li> </ol>	E INC DN ROAD N		<u>02</u> 13 PTIP	(L6) <b>55804</b> (L7) <b>22 CLIA</b>	<ol> <li>TYPE OF ACTIO</li> <li>Initial</li> <li>Termination</li> <li>Validation</li> <li>On-Site Visit</li> <li>Full Survey After</li> </ol>	<ol> <li>Recertification</li> <li>CHOW</li> <li>Complaint</li> <li>Other</li> </ol>
6. DATE OF SURVEY 06/30, 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 HHX 06 PRTF 07 X-Ray 08 OPT/SP	0) ESKD 10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPIG		FISCAL YEAR ENDI 06/30	NG DATE: (L35)
<ul> <li>11LTC PERIOD OF CERTIFICATION</li> <li>From (a):</li> <li>To (b):</li> <li>12. Total Facility Beds</li> <li>13. Total Certified Beds</li> </ul>	<ul><li>60 (L18)</li><li>60 (L17)</li></ul>	X B. Not in Com	ce With quirements	15:	2. 3. 4. X5. * Code:	Technical Personnel 24 Hour RN 7-Day RN (Rural SNF) Life Safety Code <b>B,5</b>	Following Requirements: 6. Scope of S 7. Medical Di 8. Patient Roo 9. Beds/Room (L12)	ervices Limit rector m Size
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 60 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILI 1861 (e) (	1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMARK See Attached Remarks		HOW LTC CANCELL	ATION DATE):					
17. SURVEYOR SIGNATURE Susan Frericks, HPR	SWS	Date :	08/12/2016	(L19)	18. STATE	SURVEY AGENCY AP Mark Theo Enforcement Speci	th	Date: 08/15/2016 (L20)
	PART II - TO	BE COMPLETE	D BY HCFA RE	GIONAL	OFFICE (	OR SINGLE STAT	'E AGENCY	(*)_
19. DETERMINATION OF ELIGIBILITY          1. Facility is Eligible to Part          2. Facility is not Eligible	icipate (L21)		PLIANCE WITH CI ITS ACT:	VIL	21.		ial Solvency (HCFA-2572) interest Disclosure Stmt (HG	CFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 07/01/1977 (L24)	23. LTC AGREEM BEGINNING (L41)		4. LTC AGREEMEN ENDING DATE (L25)		<u>VOLUNTAI</u> 01-Merger, 0 02-Dissatisfa	Closure action W/ Reimbursemen	05-Fail to	(L30) <u>NTARY</u> Meet Health/Safety Meet Agreement
25. LTC EXTENSION DATE: (L27)	<ol> <li>ALTERNATIVI</li> <li>A. Suspension of</li> <li>B. Rescind Sus</li> </ol>	of Admissions:	(L44) (L45)			nvoluntary Termination ason for Withdrawal	OTHER 07-Provid 00-Active	ler Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/C	ARRIER NO.		30. REMAR	RKS		
	(L28)	03001		(L31)				
31. RO RECEIPT OF CMS-1539		03001	DF APPROVAL DAT					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

ID: 8ZVO Facility ID: 00594

#### 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.



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:

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit; Lakeshore Inc July 18, 2016 Page 2

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

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

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

## DEPARTMENT CONTACT

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

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;

Lakeshore Inc July 18, 2016 Page 3

- 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.

## Lakeshore Inc July 18, 2016 Page 4 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

Lakeshore Inc July 18, 2016 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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 Lakeshore Inc July 18, 2016 Page 6

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

Enclosure

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROV							
		& MEDICAID SERVICES				0.0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY MPLETED	
		245215	B. WING		06	/30/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
LAKESH	ORE INC			4002 LONDON ROAD DULUTH, MN 55804			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		D BE	COMPLETION DATE	
F 000	INITIAL COMMENT	ſS	F 00	0			
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve f compliance upon the otance. Because you are your signature is not required first page of the CMS-2567 ic submission of the POC will tion of compliance.					
	on-site revisit of you validate that substa	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with					
F 241 SS=D	substantiated.	039 was investigated and not AND RESPECT OF	F 24	.1		8/8/16	
	manner and in an e enhances each res	omote care for residents in a nvironment that maintains or ident's dignity and respect in is or her individuality.					
	by: Based on observat review, the facility f maintained for 2 of reviewed for dignity	NT is not met as evidenced ion, interview and document ailed to ensure dignity was 3 residents (R90, R111)		F241 1. Corrective Action: A. Resident s #R90 and R111 h discharged.	nave		
	Finding include:						
	night shift she was	/16, at 10:10 a.m. that on the told by staff to just let it (urine) nable to hold her urine after		<ol> <li>Corrective Action as it applies Other Residents:</li> <li>A. The policy/procedure for Qua</li> </ol>			
LABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE	
Electron	ically Signed					07/26/2016	

**Electronically Signed** 

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.

PRINTED: 08/12/2016

		AND HUMAN SERVICES			FORM	08/12/2016 APPROVED 0938-0391
STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		245215	B. WING _		06/3	30/2016
NAME O	F PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKES	HORE INC			4002 LONDON ROAD DULUTH, MN 55804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 24	<ul> <li>putting the call light assistance.</li> <li>R90's Admission Raindicated R90's diates the right lower leg, chronic kidney dises</li> <li>The admission Min 5/22/16, indicated F cognition. R90 did r or rejection of caress incontinent of urine program. R90 need with bed mobility, tr toilet use and person</li> <li>The Bowel and Black 5/22/16, indicated F was alert and orien the need to use the A Urinary Incontine 6/1/16 to 6/29/16, in continent on the datime on the afternoon night shift.</li> <li>On 6/27/16, at 10:1 night she has had t to answer her call li caused her to wet t asked the night stattakes them so long uncomfortable, just urine). R90 stated s uncomfortable and</li> </ul>	<ul> <li>c on waiting a long time for</li> <li>ecord printed on 6/30/16, gnoses included, a fracture of a history of falls, severe ase and insomnia.</li> <li>imum Data Set (MDS) dated R90 had moderately impaired not have psychosis, behaviors s. R90 was frequently but was not on a toileting led the assistance of two staff ansfers, ambulation, dressing, onal hygiene.</li> <li>dder Assessment dated R90 was frequently incontinent, tated and was always aware of toilet.</li> <li>nce monitoring tool dated ndicated R90 was always aware of toilet.</li> <li>nce monitoring tool dated ndicated R90 was always aware of toilet.</li> <li>0 a.m. R90 stated during the o wait 20-30 minutes for staff ght. Waiting for staff had he bed. R90 stated when she ff what she should do when it . The staff told her if it gets too let it go (be incontinent of she felt terrible, cold, wet,</li> </ul>	F 24	<ul> <li>Life-Dignity was reviewed and a Po and Procedure on Cleaning of Room include cleaning of toilets.</li> <li>B. The Policy and Procedure for Co of Life-Dignity and Cleaning of Room be reviewed with facility staff on 7/2 7/30/16, 8/1/16, 8/2/16, 8/3/16, 8/4/ 8/5/16, 8/6/16.</li> <li>3. Date of Completion: 8/8/16.</li> <li>4. Reoccurrence will be Prevented A. Staff education on The Policy a Procedure for Quality of Life-Dignity Cleaning of Rooms will be reviewed facility staff on 7/27/16, 7/30/16, 8/1 8/2/16, 8/3/16, 8/4/16, 8/5/16, 8/6/1 upon hire, annually, and as needed B. DON or designee will conduct r audits daily for one month, then we one month and then monthly for on quarter. Findings will be reported to QAPI team for review and discussio</li> <li>5. The Correction will be Monitore A. DON or designee.</li> <li>B. The QAPI Committee will review audit results on a quarterly basis ar provide further direction, as needed</li> </ul>	ms to Quality ms will 27/16, 16, 16, 16, 16, 16, 16, 16, 16, 16,	

If continuation sheet Page 2 of 16

		AND HUMAN SERVICES				FORM	08/12/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245215	B. WING	i		06/:	30/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKESH	ORE INC				002 LONDON ROAD DULUTH, MN 55804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 241	facility she live in an While there, at nigh bathroom herself at until coming to the came to the facility so she had to wait a bedpan. R90 points board that stated no not know why she of she used the bedpa the sign appeared a herself when she us On 6/30/16, at 7:10 stated R90 was cor day shift. R90 could able to tell when sh have possibly been bedpan if it spilled. able, therapy took t get up at night like assisted living. On 6/30/16, at 7:40 (DON) stated staff any resident to be i not have to wait tha answered and the f incontinent. On 6/30/16, at 9:00 verified R90 was co was incontinent afte R90 had been using facility tried the com brought R90 to the	le times. Prior to coming to the n assisted living apartment. It she got up and went to the nd was not incontinent of urine facility. R90 stated after she they would not let her get up and can no longer use the ed to a sign on the dry erase o bedpan. R90 stated she did could not use a bedpan. When an at first it worked fine then and she never had to wet sed the bedpan. a.m. nursing assistant (NA)-A ntinent of urine with her on the d put on the call light and was e had to urinate. R90 could wet when she used the After awhile when R90 was he bedpan away so she would she did when she lived at the a.m. the director of nursing should not be telling R90 or ncontinent. Residents should at long for the call light to be acility did not want R90 to be a.m. registered nurse (RN)-A patinent during the day then er about 8:00 p.m. RN-A stated g the bedpan at night, then the nmode at the bedside and then	F2	241			

If continuation sheet Page 3 of 16

		AND HUMAN SERVICES			FORM	08/12/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245215	B. WING		06/;	30/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKESH	ORE INC			4002 LONDON ROAD DULUTH, MN 55804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 241	responding to resid assistance. A policy was requested, but The daily unit clean facility did not addre bathrooms. R111's Admission F that included weak sclerosis, type II dia disease and depend R111's admission M R111 was cognitive behavior symptoms assistance with bec and toileting. R111's care plan da was dependent on needs due to decre On 06/28/16, at 8:3 wait twenty minutes toilet on Saturday, 6 stool running out ar toilet was still dirty f stated he had told r At 8:45 a.m. R111's dark, dried and crus bowl and smeared seat with a small ar of the seat. At 10:29 toilet seat and state by housekeeping of On 6/29/16, at 12:2	to promote dignity by promptly lent's requests for toileting y on cleaning resident rooms not provided by the facility. hing schedule provided by the less cleaning resident Record identified diagnoses ness, amyotrophic lateral abetes mellitus, chronic kidney dence on renal dialysis. MDS dated 6/17/16, indicated ly intact, exhibited no mood or s, and required extensive d mobility, transfers, walking ated 6/22/16, indicated R111 staff for meeting physical eased mobility. 44 a.m. R111 stated he had to s for assistance when on the 6/25/16. R111 said he had nd all over the toilet, and his from that occurrence. R111 hursing staff his toilet was dirty. a toilet was observed to have sted stool on the top of the over most of the bottom of the mount of dried stool on the top 9 a.m. RN-B observed R111's ed it should have been cleaned	F 241			

If continuation sheet Page 4 of 16

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/12/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245215	B. WING		06/30/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKESH	ORE INC			1002 LONDON ROAD DULUTH, MN 55804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241 F 242 SS=D	several days. On 6/30/16, at 8:00 director (ED) stated daily and checked r a health problem su diarrhea. On 6/30/16, at 2:17 resident was knowr afternoon nursing a several times in bet cleanings. The DON assistants should h they noticed this, ar assistants did clear 483.15(b) SELF-DE MAKE CHOICES The resident has th schedules, and hea her interests, assess interact with membor inside and outside t about aspects of his are significant to the This REQUIREMEN by: Based on interview facility failed to home	a.m. the environmental bathrooms were cleaned nore often if the resident had uch as incontinence or p.m. the DON stated the to have loose stools and an ssistant had cleaned the toilet ween housekeeping N stated other nursing ave cleaned the toilet when the toilet consistently. ETERMINATION - RIGHT TO e right to choose activities, lith care consistent with his or isments, and plans of care; ers of the community both he facility; and make choices s or her life in the facility that e resident. NT is not met as evidenced v and document review, the or resident choices for r 1 of 3 residents (R90)	F 241			8/8/16
	Findings include:					

Facility ID: 00594

If continuation sheet Page 5 of 16

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245215 **B** WING 06/30/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 LONDON ROAD LAKESHORE INC **DULUTH, MN 55804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 242 Continued From page 5 F 242 R90's Admission Record printed on 6/30/16, 2. Corrective Action as it applies to indicated R90's diagnoses included a fracture of Other Residents: the right lower leg, a history of falls, severe A. The policy/procedure for Quality of chronic kidney disease and insomnia. Life-Self Determination and Participation was reviewed. B. The Policy and Procedure for Quality The admission Minimum Data Set (MDS) dated 5/22/16, indicated R90 had moderately impaired of Life-Self Determination and cognition. R90 did not have psychosis, behaviors Participation will be reviewed with facility staff on. 7/27/16, 7/30/16, 8/1/16, 8/2/16, or rejection of cares. R90 was frequently 8/3/16, 8/4/16, 8/5/16, and 8/6/16. incontinent of urine but was not on a toileting program. R90 needed the assistance of two staff C. All current residents will be asked with bed mobility, transfers, ambulation, dressing, what time they would like to get up in the toilet use and personal hygiene. morning, what time would they like to go to bed at night, how often and when they On 6/27/16, at 9:54 a.m. R90 stated staff wake would like a shower, what time they would her up about 7:00 a.m. or sometimes a little like their meals, and if they would like a earlier to take her vitals. R90 stated they tell her snack and what time to ensure that all she can go back to sleep but then she's wide residents have the right to choice. awake. R90 stated she told someone at the desk but they keep doing it and it had been happening 3. Date of Completion: 8/8/16. since she came to the facility and it was still going on. R90 stated she had told the nursing assistant 4. Reoccurrence will be Prevented by: (NA) that usually got her up between 7:00 a.m. A. Staff education on The Policy and and 7:30 a.m. that she did not want to get up until Procedure for Quality of Life-Self 8:00 a.m. R90 stated the NA was pretty firm Determination and Participation will be about getting R90 up. Nice but firm about what reviewed with facility staff on 7/27/16, the NA had to do. 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, On 6/28/16, at 2:30 p.m. R90 reconfirmed liked to annually, and as needed. get up at 8:00 a.m. and told staff during the care conference a week or so ago she wanted to stay B. All residents will be asked on in bed until 8:00 a.m. R90 stated nothing admission what time they would like to get changed. R90 futher stated even if she wakes up up in the morning, what time they would like to go to bed at night, how often and early she liked to stay in bed until 8:00 a.m. because it was nice to know you have time to when they would like a shower, what time snuggle in for awhile. they would like their meals, and if they would like a snack and what time to On 6/30/16, at 6:54 a.m. NA-B was observed ensure that all residents have the right to going from room to room obtaining resident vitals. choice.

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00594

PRINTED: 08/12/2016

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245215 B. WING 06/30/201 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 LONDON ROAD DULUTH, MN 55804 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL			AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/12/2016 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE         LAKESHORE INC       9002 LONDON ROAD DULUTH, MN 55804         (X4) ID PREFX TAG       SUMMARY STATEMENT OF DEFICIENCIES (EACH ODRECTIVE ACTION SHOULD BE REQUATORY ON LSC UBNTIFING NFORMATION)       ID PREFX TAG       PROVIDER'S PLAN OF CORRECTIVE (EACH ODRECTIVE ACTION SHOULD BE (EACH ODRECTIVE ACTION SHOULD BE DEFICIENCY)       CONSTRUCTIVE (EACH ODRECTIVE ACTION SHOULD BE CROSS REFERENCTIVE ACTION SHOULD BE DEFICIENCY)       CONSTRUCTIVE (EACH ODRECTIVE ACTION SHOULD BE CROSS REFERENCTIVE ACTION SHOULD BE DEFICIENCY)         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 indicating so. R90 did not have as ign on the door indicating so. R90 did not have as ign on the door. On 6/30/16, at 7:10 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.       F 242         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 until 8:00 because she had fallen.       Stated R90 and toget up until 8:00 a.m. was the time R90's caregiver arrived and repeatedly told R90 ont to get up until 8:00 because she had fallen.       Stated She did OT cares (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						(X3) DATE SURVEY COMPLETED	
4002 LONDON ROAD DULUTH, MN 55804       OPAL ID PREEX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH OPERCETIVE ACTION SHOULD BE (EACH OPERCETIVE ACTION (EACH OPERCETIVE ACTION SHOULD BE (EACH OPERCETIVE ACTION (EACH OPERCETIVE ACTION SHOULD BE (EACH OPERCETIVE ACTION (EACH OPERCETIVE (CTOSS-REFERENCE OT OTHE APPROPRIATE (CTOSS-REFERENCE OTH EAPPROPRIATE (CTOSS-REFERENCE OTH ACTION (EACH OPERCETIVE ACTION (EACH OPERCETIVE (CTOSS-REFERENCE OTH ACTION (EACH OPERCETIVE (CTOSS-REFERENCE OTH ACTION (CTOS) (Stated TA: 10 a.m. NA-A stated she got Inc. (CTOS) (Stated TA: 40 a.m. The director of nursing (DON) stated BA'DO a.m. Rejustered nurse (RN)-A stated she did not have any request from R90 to not be awakened or gotten up untill 8::00 a.m. Should have been honored. (CTOS) (Stated TA: 50 a.			245215	B. WING		06/30/2016	
LAKESHORE INC     DULUTH, MN 55804       [X4]ID TAG     ISUMMARY STATEMENT OF DEFICIENCIES PREFIX REQUATORY OR LSC IDENTIFYING INFORMATION)     ID REACH DERIVERS PLAN OF CORRECTION (EACH DERIVERS PLAN OF CORRECTION ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     ON COSS-REFERENCED TO THE APPROPRIATE DEFICIENCY     ON DATE       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. R80 did not have a sign on the door.     F 242       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.     F 100 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 talls while trying to get up at the assisted living, was incontinent of urine in the morning and was locosing weight while at the facility so it was important for R90 to get up of breakfast. 8:00 a.m. was the time R90's caregues raived and repeatedly told R90 not to get up until 8:00 because she had fallen.     S. The CAPI Committee will review the audit results on a quarterity basis and provide further direction, as needed.       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 any request from R90 to not be awakened or gott up up until 8:00 because she had fallen.     S. The CAPI Committee will exit the sub- sub a.m. Key the sub of the order of the ray of the sub of the availed repeatedly told R90 on to get up until 8:00 because she had fallen.       On	NAME OF F	PROVIDER OR SUPPLIER					
PRÉFIX TAG       (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÉFIX TAG       CLACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PRÉFIX TAG       CLACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEDED TO THE APPROPRIATE DEFICIENCY)       COMM         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 indicating so. R90 did not have a sign on the door indicating so. R90 did not have a sign on the door indicating so. R90 did not have a sign on the door indicating so. R90 did not have a sign on the door indicating so. R90 did not have a sign on the door indicating so. R90 did not have a sign on the door indicating so. R90 did not have a sign on the door indicating so. R90 did not have a sign on the door indicating so. R90 did not have a sign on the door indicating so. R90 did not have a sign on the door indicating so. R90 did not have a sign on the door indicating so. R90 did not have a sign on the door indicating so. R90 did not have a sign on the door indicating so. R90 did not flop of packasts 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.       F 242         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.       N no 30 (f, 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.       N no 40 (f)	LAKESH	ORE INC					
<ul> <li>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.</li> <li>R90 did not have a sign on the door.</li> <li>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 hat was her schedule at the facility was to get up early because of therapy.</li> <li>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 talls 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 out 18:00 because she had fallen.</li> <li>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.</li> <li>On 6/30/16, at 9:00 a.m. registered nurse (RN)-A stated residents were not asked specifically what time they wanted to get up.</li> </ul>	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	(X5) COMPLETION DATE
resident choices.	F 282	NA-B stated this wa vitals. NA-B did not if there is not a sign R90 did not have a On 6/30/16, at 7:10 up between 7:15 a. verified R90 had tol bed until 8:00 a.m. assisted living. The get up early becaus On 6/30/16, at 7:20 (OT)-A stated she c around 7:30 a.m. be trying to get up at th incontinent of urine loosing weight while important for R90 to a.m. was the time F repeatedly told R90 because she had fa On 6/30/16, at 7:40 (DON) stated R90's 8:00 a.m. should ha On 6/30/16, at 9:00 stated she did not h not be awakened of RN-A stated residen what time they wan The facility was una resident choices. 483.20(k)(3)(ii) SEF	as the time she usually did the do a resident's vitals this early on the door indicating so. sign on the door. a.m. NA-A stated she got R90 m. and 7:20 a.m. NA-A d her she wanted to stay in but that was her schedule at schedule at the facility was to se of therapy. a.m. occupational therapist did OT cares with R90 usually ecause R90 had falls while he assisted living, was in the morning and was e at the facility so it was o get up for breakfast. 8:00 R90's caregiver arrived and not to get up until 8:00 allen. a.m. the director of nursing s request to get up at ave been honored. a.m. registered nurse (RN)-A have any request from R90 to r gotten up until 8:00 a.m. ints were not asked specifically ted to get up. able to provide a policy on RVICES BY QUALIFIED		<ul> <li>C. DON or designee will conduct r audits daily for one month, then we one month and then monthly for on quarter. Findings will be reported to QAPI team for review and discussion</li> <li>5. The Correction will be Monitore A. DON or designee.</li> <li>B. The QAPI Committee will revie audit results on a quarterly basis ar provide further direction, as needed</li> </ul>	ekly for e o the on. ed by: w the nd d.	8/8/16

If continuation sheet Page 7 of 16

		AND HUMAN SERVICES & MEDICAID SERVICES			FOF	ED: 08/12/2016 MAPPROVED O. 0938-0391		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION (X3) D	(X3) DATE SURVEY COMPLETED		
		245215	B. WING			6/30/2016		
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
LAKESH	ORE INC				02 LONDON ROAD ULUTH, MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 282	The services provided by accordance with eacare.	ge 7 led or arranged by the facility y qualified persons in ch resident's written plan of NT is not met as evidenced	F2	282				
	by: Based on observat review, the facility fa was followed for pre	ion, interview and document ailed to ensure the care plan essure ulcer interventions for 1 5) reviewed for pressure			F282 Services by Qualified Persons/Pe Care Plan 1. Corrective Action: A. Resident #R325 has discharged.	r		
	indicated R325's dia after surgery of the of left foot toes, per 2 diabetes, polyneu disease, heart disea The Skin Care Plan R325 had a suspect right heel. Intervent reposition when in b chair and offload at hour. The nursing assistant directed staff to turr bed and offload eve On 6/29/16, R325 w from 4:45 p.m. until	Record printed 6/30/16, agnoses included after care circulatory system, absence ipheral vascular disease, type ropathy, chronic kidney ase and gout. • effective 6/7/16, indicated ted deep tissue injury on the ions included turn and bed. Reposition when in the least for one minute every and (NA) care guide (not dated) on and reposition R325 when in ery hour when in the chair. vas continuously observed 6:40 p.m. when the to inquire about R325's need			<ol> <li>Corrective Action as it applies to Other Residents:         <ul> <li>The Policy and Procedure for Using the Care Plan and Care Planning-Interdisciplinary Team was reviewed.</li> <li>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.</li> <li>Licensed Nurses and NA/R s will b 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.</li> </ul> </li> <li>Date of Completion: 8/8/16.</li> <li>Reoccurrence will be Prevented by:</li> </ol>	e		
	to be offloaded eve				<ul><li>A. Staff education on The Policy and Procedure for Using the Care Plan and</li></ul>			

Facility ID: 00594

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245215 B. WING 06/30/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 LONDON ROAD LAKESHORE INC **DULUTH, MN 55804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 282 Continued From page 8 F 282 At 4:45 p.m. R325 was up in wheelchair in his Care Planning-Interdisciplinary Team will room. Staff then brought R325 to the dining room. be reviewed with facility staff on 7/27/16, At 6:09 p.m. R325 was brought back to his room 7/30/16, 8/1/16, 8/2/16, 8/3/16, 8/4/16, by staff and remained sitting up in the wheelchair. 8/5/16, and 8/6/16.and upon hire, Offloading was not provided or offered. At 6:15 annually, and as needed. p.m. a NA entered R325's room and closed the B. Licensed Nurses and NA/R s will be door. The NA was in the room for approximately educated on pressure ulcer interventions including off loading, turn and reposition 20 seconds. and the group sheets as the plan of care At 6:40 p.m. registered nurse (RN)-A was asked for the resident need to be followed how often R325 was to offload. RN-A stated every education on 7/27/16, 7/30/16, 8/1/16, hour. At 6:55 p.m. NA-E entered with the 8/2/16, 8/3/16, 8/4/16, 8/5/16, and 8/6/16 stand-aide. NA-E stated she boosted R325 back C. DON or designee will conduct random in the chair by pulling on the back of his pants at audits daily for one month, then weekly for approximately 6:20 p.m. but did not stand or one month and then monthly for one offload R325. At 6:58 p.m. R325 stood with the guarter. Findings will be reported to the Stand Aid (mechanical lift). R325's buttocks were QAPI team for review and discussion. observed with RN-A. R325's buttocks were not red and did not have any open areas. 5. The Correction will be Monitored by: A. DON or designee. On 6/29/16, at 6:30 p.m. R325 stated he napped B. The QAPI Committee will review the on the bed until he got up for supper. R325 could audit results on a quarterly basis and not remember what time he got up. R325 stated provide further direction, as needed. 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 309 483.25 PROVIDE CARE/SERVICES FOR F 309 8/8/16 HIGHEST WELL BEING SS=D Each resident must receive and the facility must provide the necessary care and services to attain

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 9 of 16

PRINTED: 08/12/2016

		AND HUMAN SERVICES & MEDICAID SERVICES			F		08/12/2016 PPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245215	B. WING			06/3	0/2016	
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
LAKESH	ORE INC				02 LONDON ROAD JLUTH, MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE	
F 309	mental, and psycho accordance with the and plan of care. This REQUIREMEN by: Based on interview facility failed to ensi- dialysis as ordered reviewed for dialysis Findings include: R111's Admission F that included chron dependence on ren Minimum Data Set indicated R111 was mood or behavior s extensive assistand walking and toileting R111 had an active insufficiency or end R111's Order Repo outpatient dialysis of Fridays at 6:30 a.m	Ar is not met as evidenced v and document review, the ure a bag lunch was sent to for 1 of 1 residents (R111) s. Record identified diagnoses ic kidney disease and al dialysis. R111's admission (MDS) dated 6/17/16, cognitively intact, exhibited no ymptoms, and required se with bed mobility, transfers, g. The MDS further indicated diagnosis of renal stage renal disease. rt dated 6/10/16, directed on Mondays, Wednesday, . The Order Report further ad a bag lunch with R111 to	F 3	09	<ul> <li>F309 Provide Care/ Services for High Well Being</li> <li>1. Corrective Action: <ul> <li>A. Resident #R111 has discharged.</li> </ul> </li> <li>2. Corrective Action as it applies to Other Residents: <ul> <li>A. The policy/procedure for End-Stag Renal Disease, Care of a Resident wit has been reviewed and revised to incl to check Treatment Orders for what m and when the patient should receive the meal on dialysis days to ensure that a dialysis resident receive their meal.</li> <li>B. The Policy and Procedure for End-Stage Renal Disease, Care of a Resident 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.</li> </ul> </li> </ul>	ige ith Iude neal the all d		
	picked up for dialys bag lunch with R11 On 6/29/16, at 12:1	rected staff R111 would be is at 5:45 a.m. and to send a			<ul> <li>C. Currently we have no dialysis residents.</li> <li>3. Date of Completion: 8/8/16.</li> <li>4. Reoccurrence will be Prevented b</li> <li>A. Licensed Nurses will be educated The Policy and Procedure for End-Sta</li> </ul>	don		

Facility ID: 00594

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245215 B. WING 06/30/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 LONDON ROAD LAKESHORE INC **DULUTH, MN 55804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 309 Continued From page 10 F 309 dialysis procedures. R111 further stated the Renal Disease, Care of a Resident on facility staff had never sent a bag lunch with him 7/27/16, 7/30/16, 8/1/16, 8/2/16, 8/3/16, to dialysis and since no food was sent, he never 8/4/16, 8/5/16, and 8/6/16.and upon hire, ate anything while at dialysis. annually, and as needed. B. On admission the E-TAR and care On 6/29/16, nursing assistant (NA)-F stated R111 plan will indicate what meal and when the returned to the facility at 11:00 a.m. after dialysis. resident should receive the meal on NA-F said she wasn't aware of how R111 dialysis days to ensure that all dialysis received a morning meal on those days. residents receive their meal. C. DON or designee will conduct random On 6/29/16, at 6:14 p.m. registered nurse (RN)-B audits daily for one month, then weekly for stated the process for preparing R111 for dialysis one month and then monthly for one was waking R111 and getting him ready. RN-B guarter. Findings will be reported to the further stated staff would look in the appointment QAPI team for review and discussion. book and care plan for transportation and meal instructions. RN-B said she was not aware that 5. The Correction will be Monitored by: meals were not sent with R111, and meals should A. DON or designee. have been sent with him each to dialysis B. The QAPI Committee will review the appointment. audit results on a guarterly basis and provide further direction, as needed. 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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

If continuation sheet Page 11 of 16

PRINTED: 08/12/2016

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/12/2016 APPROVED 0938-0391
STATEMENT				IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245215	B. WING _		06/3	30/2016
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKESH	ORE INC			4002 LONDON ROAD DULUTH, MN 55804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa dialysis patient befo	-	F 30	99		
	(DON) stated the ni the bag lunch one to there had been no o	p.m. the director of nursing ght nurse said R111 refused ime. The DON further stated quality assurance done rocesses or assurance the s was followed.				
F 314 SS=D	access care lacked		F 31	4		8/8/16
	resident, the facility who enters the facil does not develop pr individual's clinical of they were unavoida pressure sores rece	rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and from developing.				
	by: Based on observat review, the facility fa repositioning accord assessed needs to	NT is not met as evidenced ion, interview and document ailed to provide timely ding to the resident's prevent the development of 1 of 3 residents (R325) ire ulcers.		F314 Treatment/Services to Preve Pressure Sores 1. Corrective Action: A. Resident #R325 has discharge		
	Findings include:			2. Corrective Action as it applies t	0	
	Pressure Ulcer Stag	ges (defined by the National		Other Residents: A. The policy/procedure for Skin		

Event ID:8ZVO11

Facility ID: 00594

If continuation sheet Page 12 of 16

#### FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245215 **B** WING 06/30/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4002 LONDON ROAD LAKESHORE INC **DULUTH, MN 55804** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PRÉFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 314 Continued From page 12 F 314 Pressure Ulcer Advisory Panel) include: Assessment and Care and Care Planning IDT have been reviewed. B. The Policy and Procedure for Skin Stage I: Non-blanchable erythema Assessment and Care and Care Planning Intact skin with non-blanchable redness of a IDT will be reviewed with Licensed localized area usually over a bony prominence. Nurses, NA/R and Therapy staff on The area may be painful, firm, soft, warmer or 7/27/16, 7/30/16, 8/1/16, 8/2/16, 8/3/16, cooler as compared to adjacent tissue. 8/4/16, 8/5/16, 8/6/16. C. All current residents care plans and Deep Tissue Pressure Injury: Persistent group sheets have been reviewed for non-blanchable deep red, maroon or purple pressure ulcer interventions. discoloration D. Those residents that currently have Intact or non-intact skin with localized area of pressure ulcers are being audited for persistent non-blanchable deep red, maroon off-loading, turn and reposition to ensure purple discoloration or epidermal separation the prevention of pressure ulcers. revealing a dark wound bed or blood filled blister. E. Licensed Nurses, NA/R and Therapy Pain and temperature change often precede skin staff educated on following the plan of color changes. care (group sheets) for residents, definition of off -loading, turn and R325's Admission Record printed 6/30/16, repositioning to ensure the prevention of indicated R325's diagnoses included after care pressure ulcers. after surgery of the circulatory system, absence of left foot toes, peripheral vascular disease, type Date of Completion: 8/8/16 2 diabetes, polyneuropathy, chronic kidney disease, heart disease and gout. 3. Reoccurrence will be Prevented by: A. Licensed Nurses, NA/R s and A Skin Assessment dated 6/7/16, indicated R325 was at risk for pressure ulcers. R325 had a Therapy staff will be educated on The pressure relieving mattress on the bed and Policy and Procedure for Skin cushion on the wheelchair. R325 had a Assessment and Care and Care Planning suspected deep tissue injury to the right heel, IDT on 7/27/16, 7/30/16, 8/1/16, 8/2/16, blanchable redness on the upper gluteal cleft, a 8/3/16, 8/4/16, 8/5/16, 8/6/16 and upon 0.3 centimeter (cm) skin tear, scabbed and flaky hire, annually, and as needed. skin on the left buttock and multiple areas of B. Licensed Nurses, NA/R and Therapy blanchable redness on both buttocks. The staff educated on following the plan of assessment further indicated staff was to assist care (group sheets) for residents, with turning and repositioning every two hours definition of off -loading, turn and and offload (relieve pressure to an area for a repositioning to ensure the prevention of minimum of one full minute) every hour. pressure ulcers on 7/27/16, 7/30/16,

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00594

If continuation sheet Page 13 of 16

PRINTED: 08/12/2016

-	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	( )	IG		PLETED
		245215	B. WING _		06/:	30/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
LAKESH	IORE INC			4002 LONDON ROAD DULUTH, MN 55804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 314	Continued From pa	age 13	F 31	4		
	indicated the upper blanchable redness flaky on the left but healed. An order we foam type dressing R325's admission dated 6/16/16, indi intact, had no beha R325 needed the es staff with bed mobi R325 needed the es staff with dressing did not walk. R325 and had one deep have any venous of pressure relieving chair. R325 receive wound care. The Skin Care Plai R325 had a susper right heel related to disease and diabet and reposition whe the chair and offloa hour. The care plai an alternating air p and received a bar The nursing assist directed staff to tur	Minimum Data Set (MDS) cated R325 was cognitively aviors or rejection of cares. extensive assistance of two ility, transfers and toilet use. extensive assistance of one and personal hygiene. R325 was at risk for pressure ulcers tissue injury. R325 did not or arterial ulcers. R325 had devices on the bed and in the ed pressure ulcer and surgical n effective 6/7/16, indicated cted deep tissue injury on the o the diagnoses of vascular tes. Interventions included turn en in bed. Reposition when in ad at least for one minute every n further indicated R325 had ressure mattress on the bed rrier cream to the gluteal cleft. ant (NA) care guide (not dated) m and reposition R325 when in		<ul> <li>8/1/16, 8/2/16, 8/3/16, 8/4/16, 8/5</li> <li>8/6/16 and upon hire, annually, at needed.</li> <li>C. DON or designee will conduct audits daily for one month, then wo one month and then monthly for a quarter. Findings will be reported QAPI team for review and discus</li> <li>4. The Correction will be Monitot A. DON or designee.</li> <li>B. The QAPI Committee will revaudit results on a quarterly basis provide further direction, as need</li> </ul>	nd as t random veekly for one to the sion. ored by: iew the and	
	wound care. The Skin Care Plat R325 had a susper right heel related to disease and diabet and reposition whe the chair and offloa hour. The care plat an alternating air p and received a bar The nursing assist directed staff to tur bed and offload ev On 6/29/16, R325 f from 4:45 p.m. unt	n effective 6/7/16, indicated cted deep tissue injury on the p the diagnoses of vascular tes. Interventions included turn en in bed. Reposition when in ad at least for one minute every n further indicated R325 had ressure mattress on the bed rrier cream to the gluteal cleft. ant (NA) care guide (not dated)				

If continuation sheet Page 14 of 16

		AND HUMAN SERVICES				FORM	08/12/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245215	B. WING			06/;	30/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKESH	ORE INC				002 LONDON ROAD DULUTH, MN 55804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	to be offloaded eve At 4:45 p.m. R325 y room, staff entered ready to go down to to the dining room. brought back to his sitting up in the whe provided or offered. assistant (NA) ente the door. The NA w approximately 20 se At 6:40 p.m. registe how often R325 wa hour. At 6:45 p.m. F and asked him if he stated he was ready she would get his N the facility with a he his buttock but was 6:55 p.m. NA-E ent (mechanical lift). N/ back in the chair by pants at approxima stand or offload R33 with the Stand Aid. observed with RN-A foam type dressing removed the dressi red and did not hav On 6/29/16, at 6:30 on the bed until he prior to supper and	ry hour. was up in wheelchair in his and asked him if he was o supper and then brought him At 6:09 p.m. R325 was room by staff and remained eelchair. Offloading was not . At 6:15 p.m. a nursing red R325's room and closed ras in the room for econds. ered nurse (RN)-A was asked s to offload. RN-A stated every RN-A entered R325's room e wanted to lay down. R325 y to get to bed. RN-A stated IA. R325 stated he came into eart-shaped pressure ulcer on not sure if it was still there. At ered with the Stand Aid A-E stated she boosted R325 y pulling on the back of his tely 6:20 p.m. but did not 25. At 6:58 p.m. R325 stood R325's buttocks were A. R325 had a large adhesive over his coccyx area. RN-A ng. R325's buttocks were not	F3	314			

If continuation sheet Page 15 of 16

		AND HUMAN SERVICES			FORM	08/12/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245215	B. WING		06/3	30/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
LAKESH	ORE INC			1002 LONDON ROAD DULUTH, MN 55804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	On 6/30/16, at 9:00 (DON) stated she v or offload residents The facility's Skin A dated 5/11, indicate the necessary care maintain the highes psychosocial well b comprehensive ass related to skin care facility without a pre a pressure ulcer un condition proved it currently had a pres	age 15 a.m. the director of nursing yould expect staff to reposition as directed by the care plan. Assessment and Care policy ed each resident would receive and services to attain or at physical, mental and eing in accordance with the sessment and care plan A resident who entered the essure ulcer would not develop less the resident's clinical unavoidable. A resident who sure ulcer would receive the at and services to promote t new pressure ulcers.	F 314			

Facility ID: 00594

If continuation sheet Page 16 of 16

		AND HUMAN SERVICES & MEDICAID SERVICES		Ŧ	5215027	FORM	07/27/2016 APPROVED 0938-0391
STATEMENT	OF DÉFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` '	LTIPL	E CONSTRUCTION 02 - NEW REPLACEMENT BLDG		E SURVEY PLETED
		245215	B. WING			06/2	28/2016
NAME OF I	PROVIDER OR SUPPLIER			I	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKESH	ORE INC			I	002 LONDON ROAD DULUTH, MN 55804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	rs	ĸ	000			
). B	FIRE SAFETY						
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.					
	ONSITE REVISIT O CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN DF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN TH YOUR VERIFICATION.					ia.
	Minnesota Departm Fire Marshal Divisio Lakeshore Inc. was compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National I	Survey was conducted by the bent of Public Safety, State on. At the time of this survey, found not in substantial e requirements for participation at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association 01, Life Safety Code (LSC), ealth Care.			2		
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K	R THE FIRE SAFETY			EPO(	1	
	HEALTH CARE FIF STATE FIRE MARS 445 MINNESOTA S ST. PAUL, MN 551	SHAL DIVISION STREET, SUITE 145					
ABORATORY	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE
Electron	ically Signed						07/26/2016

**Electronically Signed** 

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.

Facility ID: 00594

		AND HUMAN SERVICES				FORM	07/27/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION IEW REPLACEMENT BLDG		E SURVEY IPLETED
		245215	B. WING			06/	28/2016
NAME OF F	PROVIDER OR SUPPLIER		r	STREE	T ADDRESS, CITY, STATE, ZIP CODE		
LAKESH	ORE INC				ONDON ROAD TH, MN 55804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	К 0	00			
	By e-mail to both: Marian.Whitney@s and Angela.Kappenmar						
		RRECTION FOR EACH T INCLUDE ALL OF THE DRMATION:					
	1. A description of to correct the defici	what has been, or will be, done iency.		÷			
	2. The actual, or pr	oposed, completion date.					
		r title of the person rection and monitoring to ence of the deficiency					
	II(222) construction The building is fully supervised smoke	two story building of type that was built in 2004-2005. sprinklered and there is detection located in the pen to corridor and in resident					
		certified beds. All beds are are only. At the tie of the sus was 58.					
	NOT MET.	t 42 CFR Subpart 483.70(a) is	0				
K 017	NFPA 101 LIFE SA	FETY CODE STANDARD	KO	17			7/26/16
SS=E	transfer of smoke. to terminate at the	form a barrier to limit the Such walls shall be permitted ceiling where the ceiling is					
FORM CMS-2	567(02-99) Previous Versions	s Obsolete Event ID: 8ZVO2	1	Facility ID	D: 00594 If c	ontinuation she	eet Page 2 of 4

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION 02 - NEW REPLACEMENT BLDG		E SURVEY PLETED
		245215	B. WING		06/	28/2016
NAME OF	PROVIDER OR SUPPLIER		S <sup>-</sup>	TREET ADDRESS, CITY, STATE, ZIP CODE		
LAKESH	ORE INC			002 LONDON ROAD ULUTH, MN 55804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETIC DATE
K 017	resistance rating is 18.3.6.1, 18.3.6.2, This STANDARD i Based on observat revealed that the fa walls separations in Safety Code 101 (0 18.3.6.2. This defic event of a fire, allow throughout the effe making them untern affect 40 of 53 resid	the transfer of smoke. No fire required for the corridor walls.	K 017	Please see attached K084 waiver form	request	
	06/28/2016, observ level physical thera areas were open to treatment areas do	veen 10:30 AM to 1:30 PM on rations revealed that the lower py and occupational therapy the corridor. Patient not meet one of the ace allowed to be open to the				
K 018 SS=E	Maintenance Super NFPA 101 LIFE SA Doors protecting co constructed to resis Clearance between covering is not exco impediment to the o devices that release pulled are permitted positive latching ha	ition was verified by the rvisor. FETY CODE STANDARD prridor openings shall be st the passage of smoke. In bottom of door and floor beding 1 inch. There is no closing of the doors. Hold open e when the door is pushed or d. Doors shall be provided with rdware. Dutch doors meeting nitted. Roller latches shall be	K 018		z	7/26/16

		AND HUMAN SERVICES & MEDICAID SERVICES			OMB NO.	APPROVE 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	LE CONSTRUCTION 02 - NEW REPLACEMENT BLDG		E SURVEY PLETED
		245215	B. WING		06/2	28/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
	ORE INC			1002 LONDON ROAD		
				DULUTH, MN 55804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
K 018	Based on observat had multiple corridor requirements of NF (2000 edition), sect practice could affect an undetermined nut the facility. Findings include: On facility tour betw 06/28/2016, observ level physical therap corridor and there w bi-fold doors that we the physical therapy therapy area is ope around the physical	ge 3 s not met as evidenced by: tion and interview, the facility or doors that did not meet the PA Life Safety Code 101 ion 18.3.6.3.2. This deficient at 40 of 53 residents, as well as umber of staff, and visitors of veen 10:30 AM to 1:30 PM on ation revealed that the lower py area was open to the vere two sets of closets with ere located in the walls around y room. Because the physical n to the corridor the walls I therapy area must meet the prridor walls. The doors to the	K 018		iver request	
	automatically position 1/2" gap at the top of not constructed to lindo not meet the req	-fold doors that were not vely latching and there was a of the doors. The doors were imit the transfer of smoke and juirements for corridor doors. tion was verified by the visor.				

 $\hat{\alpha}$ 

## 245215

2000 CODE

07-27-2016

Page 26

## Name of Facility

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).

Surveyor (Signature) Title Office Date	PROVISION NUMBER(S)		JUSTIFICATION	
Surveyor (Signature)	K84 * K017, Item 7 Lower level treatment spaces are open to the corridor, which does not comply with NFPA 101(00), Sections	<ul> <li>A. Compliance with this provision</li> <li>1. NFPA 101(00), Sec. 4.6.3 buildings in cases where separate the physical the the housing and rehability Many of these persons u process. To maintain ear were intentionally design</li> <li>2. Due to the existence of on extended up through the to bring about due to the HVAC ducts, conduits, set</li> <li>3. Lakeshore Inc feels that effort, disruption of serv arrangement of the lower a. The lower level in 18.2.5.7 for ft<sup>2</sup> in size.</li> <li>b. There are no slee c. There are two ear these exits of</li> </ul>	In will cause an unreasonable hardship because: allows the authority having jurisdiction to modify their application would be impractical. Lakeshore rapy (PT) and occupational therapy (OT) spaces fr ation of persons in various stages of recovery from se wheelchairs, walkers, canes and/or crutches as sy access to the PT and OT spaces, as well as to re- ted to be as open and barrier free (e.g. doors) as p open grate ceiling tiles in the lower level corridor, a chop ceiling to the floor deck above. This modifi e supernumerary amount and location of building wer and water piping, fire sprinkler piping, etc.). the modification necessitated to correct this defici- ices and expense with minimal or no gain in life sa r level is very similar to that allowed by the Code a roughly 8,750 ft <sup>2</sup> in size, which is less than the 10 non-sleeping suites. The smoke zone in which the eping rooms on the lower level.	Inc feels that it would be impractical to om the corridor. Lakeshore Inc specializes in n surgery (e.g. hip and knee replacements). they progress through their recovery duce the potential for injury, these areas possible. any corridor walls constructed must be cation would prove exceptionally challenging utilities installed above the drop ceiling (e.g. ency would cause the need for inordinate fety. The facility feels that the physical for suites, based on the following: 0,000 ft <sup>2</sup> allowed by NFPA 101(00), Sec. e PT/OT spaces are located is roughly 6,070
The Anthenity Office Date	Surveyor (Signature)	Title	Office	Date
	Fire Authority Official (Signa	torel. Title	Office	Date

STATE FIRE MARSHAL

FIRE SAFETY SUPERVISE Form CMS-2786R (03/04) Frevious Versions Obsolete

#### 2000 CODE

## Name of Facility

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.	<ol> <li>The lower le</li> <li>There are a staffing rati</li> <li>Based on re the lower le</li> <li>The building with NFPA 1</li> <li>Automatics corridors ar</li> <li>The building full-time de</li> </ol>	erse impact on the safety of evel is only occupied between maximum of 18 residents of of at least one (1) staff per view of building construction vel is subdivided into two s is protected throughout b .3. moke detection, interconne of PT/OT spaces open to the grire alarm system is monit partment.	rson for each two (2) residents us on drawings and discussion with t eparate smoke compartments. y a complete supervised automat ected with the building's address e corridor on the lower level. ored to provide automatic notific	ollowing reasons: PM. ne. Staffing levels are maintained such that a sing PT and/or OT services is present. he facility architect, it has been confirmed that the facility architect, it has been confirmed that architect is present in the the facility architect is a second to the Duluth Fire Department, which is a ently displayed at all major entrances to the
Surveyor (Signature)	Title	AFETY SUPERVISOR	Office STATE FIREMA	Date 67-27-2016
Fire Authority Official (Signature)		nie y selendia e	Office	Date
Form CMS-2786R (03/04) Previou	s Versions Obsolete	and an and a second	<u>l</u>	Page 2

## Name of Facility

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).

**ILISTIFICATION** 

PROVISION NUMBER(S)			JUSTIFICATION	
Kernel (19) Kernel (19) Ker	1. NFF buil inst roo egr Inc rep rec we 2. Lak A. B.	A 101(00), Sec. 4.6.3 al ldings in cases where the tall positive latching doc mas they would restrict ess from the treatment specializes in the housi lacements). Many of t overy process. To main re intentionally designe teshore Inc feels that: The facility feels that t suites, based on the for 21ft <sup>2</sup> ). Both of these a corridor provided cert The correction of this de vices with minimal or n There are no sleep The lower level is roug for non-sleeping suites There are two exits for exits discharges direct	heir application would be impractical. Lakes ors on the 2 sets of closets with bi-fold doc ct access to and interfere with exiting from space located at the southeast corner of t ing and rehabilitation of persons in various hese persons use wheelchairs, walkers, cai intain easy access to the PT spaces, as well d to be as barrier free and open (e.g. door the physical arrangement of the lower leve ollowing: the storage areas are less than 50 areas are fully sprinklered. 18.3.6.1 except ain criteria are met. efficiency would cause the need for disprop o increase in life safety. Ding rooms on the lower level. ghly 8,750 ft <sup>2</sup> in size, which is less than the s. The smoke zone in which the PT/OT space	<ul> <li>Is very similar to that allowed by the Code for existing solution and the physical therap treatment room #4; in addition, access to and the therapy area would be restricted. Lakeshore stages of recovery from surgery (e.g. hip and knemes and/or crutches as they progress through their as to reduce the potential for injury, these areas s) as possible.</li> <li>I is very similar to that allowed by the Code for ft2 (North closet is 22.5ft<sup>2</sup> and South closet is ion #1 spaces are allowed to be open to the sortionate effort, expense and disruption of 10,000 ft<sup>2</sup> allowed by NFPA 101(00), Sec. 18.2.5.7 ces are located is roughly 6,070 ft<sup>2</sup> in size.</li> </ul>
Surveyor (Signature)		Title	Office	Date
Fire Authority Official (Signat	ture)	Title FINE SAFET/SU	Office UPERVISOR STATE FIRE	Date Date OD-27-2016 Page 2

Aden Form CMS-2786R (03/04) Previous Versions Obsolete

Page 26

## Name of Facility

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					
<84 (018, Item 4	(continued from previous	page) *	*				
an brieden Gampaniterre () - (27)	3. There will be no adverse effect on the safety of building occupants because:						
Corridor doors do not comply with NFPA 101 00), Section 18.3.6.3.	<ol> <li>There are a maximinatio of at least on</li> <li>Based on review of the lower level is set.</li> <li>The building is prowith NFPA 13.</li> <li>Automatic smoke corridors and PT/0</li> <li>The building fire a full-time department.</li> </ol>	the (1) staff person for each two (2) residents using of building construction drawings and discussion subdivided into two separate smoke compartme otected throughout by a complete supervised au detection, interconnected with the building's au OT spaces open to the corridor on the lower lev ilarm system is monitored to provide automatic ent.	ne. Sufficient staff are present to maintain a staffing ng PT and/or OT services. with the facility architect, it has been confirmed tha ents. Itomatic fire sprinkler system installed in accordance ddressable fire alarm system, is present in the				
Surveyor (Signature)	Title	Office	Date				
Surveyor (Signature) Fire Authority Official (Signat		Office	Date				

2000 CODE



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

Lakeshore Inc July 18, 2016 Page 2

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

Minneso	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00594	B. WING		06/3	0/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
LAKESH	ORE INC		DON ROAD MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 07/26/16

Electronically Signed

STATE FORM

If continuation sheet 1 of 22

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00594	B. WING		06/	30/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S <sup>-</sup>	TATE, ZIP CODE		
AKESH	ORE INC		NDON ROAD , MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLETI DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Departm On 6/27/16 through Department's staff the following correct Please indicate in y correction that you and identify the dat H Complaint H521 substantiated. Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. The assigned tag m column entitled "ID	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the nent of Health. n 6/30/16, surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, e when they will be completed 5039 was investigated and not nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for				
	"Summary Stateme and replaces the "T correction order. Th findings which are i after the statement evidence by." Follor	compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute , "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN	ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X:	B) DATE SURVEY COMPLETED
		00594	B. WING		06/30/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE	
LAKESH	ORE INC		NDON ROAD , MN 55804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 000	Continued From pa	ge 2	2 000		
		ERAL DEFICIENCIES ONLY. R ON EACH PAGE.			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 565	MN Rule 4658.0405 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		8/8/16
		omprehensive plan of care personnel involved in the			
	by: Based on observati review, the facility fa was followed for pre-	ent is not met as evidenced on, interview and document ailed to ensure the care plan essure ulcer interventions for 1 5) reviewed for pressure		Corrected.	
	Findings include:				
	indicated R325's dia after surgery of the of left foot toes, per	Record printed 6/30/16, agnoses included after care circulatory system, absence ipheral vascular disease, type iropathy, chronic kidney ase and gout.			
	R325 had a suspec right heel. Intervent reposition when in t	n effective 6/7/16, indicated eted deep tissue injury on the ions included turn and bed. Reposition when in the least for one minute every			

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00594	B. WING		06/	30/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
LAKESH	ORE INC		NDON ROAD , MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ige 3	2 565			
	hour.					
	directed staff to turi	ant (NA) care guide (not dated) n and reposition R325 when in ery hour when in the chair.				
	from 4:45 p.m. unti	vas continuously observed I 6:40 p.m. when the to inquire about R325's need ry hour.				
	room. Staff then bru At 6:09 p.m. R325 by staff and remain Offloading was not p.m. a NA entered	was up in wheelchair in his ought R325 to the dining room was brought back to his room ed sitting up in the wheelchair provided or offered. At 6:15 R325's room and closed the n the room for approximately				
	how often R325 wa hour. At 6:55 p.m. I stand-aide. NA-E s in the chair by pullir approximately 6:20 offload R325. At 6: Stand Aid (mechan	ered nurse (RN)-A was asked s to offload. RN-A stated every NA-E entered with the tated she boosted R325 back ng on the back of his pants at p.m. but did not stand or 58 p.m. R325 stood with the ical lift). R325's buttocks were A. R325's buttocks were not re any open areas.				
	on the bed until he not remember wha prior to supper and	p.m. R325 stated he napped got up for supper. R325 could t time he got up. R325 stated after returning from supper he provided repositioning or to be	9			
		a.m. the director of nursing vould expect staff to reposition				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00594	B. WING		06/	30/2016
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
LAKESH	ORE INC		NDON ROAD , MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	ige 4	2 565			
	or offload residents	as directed by the care plan.				
	The facility was una following the care p	able to provide a policy on plan.				
	The Director of Nur develop, review, an procedures to ensu- all residents. The Director of Nur educate all appropr procedures. The Director of Nur develop monitoring compliance.	THOD OF CORRECTION: rsing or designee could ind/or revise policies and irre care plans are followed for rsing or designee could riate staff on the policies and rsing or designee could systems to ensure ongoing				
2 920	(21) days.	R CORRECTION: Twenty-one	2 830			9/9/16
2 830	Proper Nursing Ca	0 Subp. 1 Adequate and re; General	2 830			8/8/16
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident bed.	1			
	This MN Requirem	ent is not met as evidenced				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00594	B. WING		06/	30/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
LAKESH	ORE INC		NDON ROAD I, MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ige 5	2 830			
	facility failed to ens	and document review, the ure a bag lunch was sent to for 1 of 1 residents (R111) s.		Corrected.		
	Findings include:					
	that included chron dependence on rer Minimum Data Set indicated R111 was mood or behavior s extensive assistant walking and toiletin R111 had an active	Record identified diagnoses ic kidney disease and hal dialysis. R111's admission (MDS) dated 6/17/16, a cognitively intact, exhibited no symptoms, and required be with bed mobility, transfers, g. The MDS further indicated diagnosis of renal I stage renal disease.				
	outpatient dialysis o Fridays at 6:30 a.m	rt dated 6/10/16, directed on Mondays, Wednesday, I. The Order Report further nd a bag lunch with R111 to ays.				
		rected staff R111 would be is at 5:45 a.m. and to send a 1.				
	facility's nursing st dialysis procedures facility staff had new	1 p.m. R111 stated the aff weren't aware of his aff weren't aware of his a R111 further stated the ver sent a bag lunch with him e no food was sent, he never at dialysis.				
	returned to the faci NA-F said she was	g assistant (NA)-F stated R111 lity at 11:00 a.m. after dialysis. n't aware of how R111 g meal on those days.				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00594	B. WING		06/3	30/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
LAKESH	ORE INC		NDON ROAD , MN 55804			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 830	Continued From pa	ige 6	2 830			
	stated the process was waking R111 a further stated staff book and care plan instructions. RN-B meals were not ser	p.m. registered nurse (RN)-B for preparing R111 for dialysis and getting him ready. RN-B would look in the appointment for transportation and meal said she was not aware that the with R111, and meals should h him each to dialysis				
	copy of R111's diet document was revie 6/10/16, R111's nar request for a renal/ diet) and dialysis M 6:30 a.m. The diet	stated she found the nursing order dated 6/10/16. The ewed and included a date of me and room number and a CCC (consistent carbohydrate londay, Wednesday, Friday at order further directed staff to or R111 on those days.				
	(FSD) stated the di a low potassium die	a.m. the food service director et order she had only included et. The FSD also said the diet sed by dietary aide.				
	stated she was just not been receiving DA-A also said the	a.m. dietary aide (DA)-A been made aware R111 had a bag lunch before dialysis. nursing unit was responsible g lunch was sent with a pre dialysis.				
	(DON) stated the n the bag lunch one t there had been no	p.m. the director of nursing ight nurse said R111 refused ime. The DON further stated quality assurance done processes or assurance the is was followed.				
	The undated facility	policy for hemodialysis				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00594	B. WING		06/	30/2016
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AKESH	IORE INC		NDON ROAD I, MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETI DATE
2 830	Continued From pa	ige 7	2 830			
		l direction on dietary need dialysis appointment.				
	The director of nurs and revise policies meals are provided dialysis. Staff could The director of nurs	THOD FOR CORRECTION: sing or designee could review and procedures for ensuring for residents who require be educated as necessary. sing or designee could monitor to ensure continued	r			
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one	9			
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			8/8/16
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which	r			
	without pressure s pressure sores unle condition demonstr	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessar	who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	This MN Requirem by:	ent is not met as evidenced				

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00594	B. WING		06/3	30/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
AKESH	ORE INC		NDON ROAD I, MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	age 8	2 900			
	review, the facility f repositioning accor assessed needs to	ion, interview and document ailed to provide timely ding to the resident's prevent the development of 1 of 3 residents (R325) ure ulcers.		Corrected.		
	Findings include:					
		ges (defined by the National visory Panel) include:				
	Stage I: Non-blancl	Stage I: Non-blanchable erythema				
	localized area usua The area may be p	I-blanchable redness of a ally over a bony prominence. ainful, firm, soft, warmer or d to adjacent tissue.				
	non-blanchable dee discoloration Intact or non-intact persistent non-blan purple discoloration revealing a dark wo	ure Injury: Persistent ep red, maroon or purple skin with localized area of inchable deep red, maroon in or epidermal separation bund bed or blood filled blister. ure change often precede skin				
	indicated R325's di after surgery of the of left foot toes, per	Record printed 6/30/16, agnoses included after care circulatory system, absence ripheral vascular disease, type uropathy, chronic kidney ase and gout.				
	was at risk for pres pressure relieving r	t dated 6/7/16, indicated R325 sure ulcers. R325 had a mattress on the bed and selchair. R325 had a				

	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		00594	B. WING		06/	30/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
	IORE INC	4002 LON	IDON ROAD			
LAKEON		DULUTH,	MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 900	Continued From pa	ige 9	2 900			
	blanchable redness 0.3 centimeter (cm) skin on the left butt blanchable redness assessment further with turning and rep and offload (relieve minimum of one ful Skin Assessments indicated the upper blanchable redness flaky on the left butt healed. An order wa foam type dressing					
	dated 6/16/16, indic intact, had no beha R325 needed the e staff with bed mobil R325 needed the e staff with dressing a did not walk. R325 and had one deep t have any venous of pressure relieving of	Minimum Data Set (MDS) cated R325 was cognitively viors or rejection of cares. xtensive assistance of two lity, transfers and toilet use. xtensive assistance of one and personal hygiene. R325 was at risk for pressure ulcers tissue injury. R325 did not r arterial ulcers. R325 had devices on the bed and in the ed pressure ulcer and surgical				
	R325 had a suspect right heel related to disease and diabeted and reposition when the chair and offloat hour. The care plan an alternating air pr	n effective 6/7/16, indicated cted deep tissue injury on the the diagnoses of vascular es. Interventions included turn n in bed. Reposition when in d at least for one minute every n further indicated R325 had ressure mattress on the bed rier cream to the gluteal cleft.				

	NT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00594	B. WING		06/	30/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
AKESH	IORE INC		NDON ROAD MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	ge 10	2 900			
	directed staff to turn bed and offload eve On 6/29/16, R325 v from 4:45 p.m. until	ant (NA) care guide (not dated) n and reposition R325 when in ery hour when in the chair. vas continuously observed 6:40 p.m. when the to inquire about R325's need ry hour.				
	room, staff entered ready to go down to to the dining room. brought back to his sitting up in the whe provided or offered.					
	how often R325 wa hour. At 6:45 p.m. F and asked him if he stated he was read she would get his N the facility with a he his buttock but was 6:55 p.m. NA-E ent (mechanical lift). N/ back in the chair by pants at approxima stand or offload R3. with the Stand Aid. observed with RN-4 foam type dressing	ered nurse (RN)-A was asked s to offload. RN-A stated every RN-A entered R325's room e wanted to lay down. R325 y to get to bed. RN-A stated IA. R325 stated he came into eart-shaped pressure ulcer on not sure if it was still there. At ered with the Stand Aid A-E stated she boosted R325 r pulling on the back of his tely 6:20 p.m. but did not 25. At 6:58 p.m. R325 stood R325's buttocks were A. R325 had a large adhesive over his coccyx area. RN-A ng. R325's buttocks were not				

TATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00594	B. WING		06/30/2016	
AME OF P	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
AKESH	ORE INC		NDON ROAD , MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	ge 11	2 900			
	On 6/29/16, at 6:30 on the bed until he not remember what prior to supper and was not offered or p offloaded. On 6/30/16, at 9:00 (DON) stated she w or offload residents The facility's Skin A dated 5/11, indicate the necessary care maintain the highes psychosocial well b comprehensive ass related to skin care facility without a pre- a pressure ulcer un condition proved it to currently had a pre- necessary treatmer healing and preven SUGGESTED MET The Director of Nur develop, review, an procedures to ensu pressure ulcer unle and residents who of receiving the prope promote healing, prinew pressure ulcer. The Director of Nur educate all appropri	p.m. R325 stated he napped got up for supper. R325 could a time he got up. R325 stated after returning from supper he provided repositioning or to be a.m. the director of nursing yould expect staff to reposition as directed by the care plan. ssessment and Care policy deach resident would receive and services to attain or at physical, mental and eing in accordance with the sessment and care plan . A resident who entered the essure ulcer would not develop less the resident's clinical unavoidable. A resident who sure ulcer would receive the nt and services to promote t new pressure ulcers. CHOD OF CORRECTION: sing or designee could d/or revise policies and re residents do not develop a ss it is clinically unavoidable, do have pressure ulcers are r care and services needed to revent infection and promote				

	IT OF DEFICIENCIES OF CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X:	3) DATE SURVEY COMPLETED
		00594	B. WING		06/30/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
AKESH	ORE INC		IDON ROAD MN 55804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
2 900	Continued From pa	ge 12	2 900		
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one			
21805	MN St. Statute 144. Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805		8/8/16
	residents have the courtesy and respe	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.			
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to ensure dignity was 3 residents (R90, R111)		Corrected.	
	Finding include:				
	night shift she was t go when she was u	/16, at 10:10 a.m. that on the told by staff to just let it (urine) nable to hold her urine after on waiting a long time for			
	indicated R90's diag	ecord printed on 6/30/16, gnoses included, a fracture of a history of falls, severe ase and insomnia.			
	5/22/16, indicated F cognition. R90 did r or rejection of cares	mum Data Set (MDS) dated R90 had moderately impaired not have psychosis, behaviors s. R90 was frequently but was not on a toileting			

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00594	B. WING		06/	30/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
LAKESH	IORE INC		NDON ROAD , MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21805	program. R90 need with bed mobility, tra- toilet use and perso The Bowel and Blac 5/22/16, indicated F was alert and orient the need to use the A Urinary Incontinen 6/1/16 to 6/29/16, ir continent on the day time on the afternoo night shift. On 6/27/16, at 10:1 night she has had to to answer her call li- caused her to wet th asked the night staf takes them so long- uncomfortable, just urine). R90 stated s uncomfortable and On 6/28/16, at 3:40 wet the bed a coupl facility she live in ar While there, at nigh bathroom herself ar until coming to the f came to the facility so she had to wait a bedpan. R90 pointer board that stated no not know why she o	ed the assistance of two staff ansfers, ambulation, dressing, onal hygiene. dder Assessment dated 890 was frequently incontinent tated and was always aware of toilet. Ince monitoring tool dated ndicated R90 was always y shift, was incontinent one on shift and nine times on the 0 a.m. R90 stated during the o wait 20-30 minutes for staff ght. Waiting for staff had he bed. R90 stated when she if what she should do when it . The staff told her if it gets too let it go (be incontinent of she felt terrible, cold, wet, humiliated. p.m. R90 stated she had to le times. Prior to coming to the n assisted living apartment. t she got up and went to the nd was not incontinent of urine facility. R90 stated after she they would not let her get up and can no longer use the ed to a sign on the dry erase o bedpan. R90 stated she did could not use a bedpan. When an at first it worked fine then and she never had to wet		DEFICIENC		

00594     IMM     06/30/2016       NAME OF PROVIDER OF SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     00/21 CONDON ROAD       LAKESHORE INC     00/21 CONDON ROAD     DULUTH, MN 55804     00/21 CONDON ROAD       MAIL 0     SUMMARY STATEMENT OF DEPICIENCES     PROVIDER'S FLAN OF CORRECTIVE ACTION SHOULD BE     00/04/11       MAIL 0     SUMMARY STATEMENT OF DEPICIENCES     PROVIDER'S FLAN OF CORRECTIVE ACTION SHOULD BE     00/04/11       MAIL 0     SUMMARY STATEMENT OF DEPICIENCES     PROVIDER'S FLAN OF CORRECTIVE ACTION SHOULD BE     00/04/11       21805     Continued From page 14     21805     DEFICIENCY     00/21 CONDON DEPICIENCES		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
AB02 LONDON ROAD DULUTH, MK 5580           OWNERS PLAN OF CORRECTION PHERK RECULTORY OR LSCIENTIFYICS INFORMATION)         DD PLETK TAG         PROVIDER'S PLAN OF CORRECTION (EACH ODRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)         OWNERT CONSS-REFERENCED TO THE APPROPRIATE DEFICIENCY           21805         Continued From page 14         21805         Difficiency         Consistent Phylopinate DEFICIENCY         Construct Phylopinate DEFIC			00594	B. WING		06/30/2016	
LAKESPORE INC     DULUTH, MN 55804       (M) ID PREEX TAG     ISUMMARY STATEMENT OF DEFICIENCIES INCOMPETED STULIN RESOLUTION OF US 10 IDENTIFYING INFORMATION     ID PREEX TAG     ID PREEX ISAC CORRECTIVE ACTION SHOULD BE CROSS REFERENCING ACTION SHOULD BE CROSS REFERENCY     (MO DEFICIENCY)       21805     Continued From page 14     21805       Continued From page 14, stated F80 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 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 sciences, up II diabetes melitus, chronic kidney disease and dependence or neal idaysis.     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 R1111 was dependent on staff for meeting physical	NAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
Image         SUMMARY STATEMENT OF DEFICIENCIES         Ip         PROVIDER'S PLAUE OF CORPECTION         Ope           1740         ECAN DEFICIENCY WIST BE FREENED BY PLIL FEAD EFFCIENCY WIST BE FREENED BY PLIL DEFICIENCY         PROVIDER'S FREENED BY PLIL CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY         Ope CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY           21805         Continued From page 14         21805         21805         Content 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 when R90 was able, therapy took the bedpan away so she would get up a 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 and 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 tolet.         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 tolleting.         R111's care plan dated 6/22/16, indicated R111 was dependent on staff for meeting Physical	AKESHO	ORE INC					
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 are 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 bediside 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 intat, 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	PRÉFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	COMPLET
neeus due to decreased mobility.		On 6/30/16, at 7:10 stated R90 was cor day shift. R90 could able to tell when sh have possibly been bedpan if it spilled. able, therapy took t get up at night like s assisted living. On 6/30/16, at 7:40 (DON) stated staff any resident to be in not have to wait that answered and the f incontinent. On 6/30/16, at 9:00 verified R90 was co was incontinent after R90 had been using facility tried the com brought R90 to the R111's Admission F that included weak sclerosis, type II dia disease and dependent R111's admission M R111 was cognitive behavior symptoms assistance with bec and toileting. R111's care plan da was dependent on s	<ul> <li>a.m. nursing assistant (NA)-A ntinent of urine with her on the d put on the call light and was the had to urinate. R90 could wet when she used the After awhile when R90 was he bedpan away so she would she did when she lived at the</li> <li>a.m. the director of nursing should not be telling R90 or ncontinent. Residents should at long for the call light to be facility did not want R90 to be</li> <li>a.m. registered nurse (RN)-A to be active day then at night, then the nmode at the bedside and then toilet.</li> <li>Record identified diagnoses ness, amyotrophic lateral abetes mellitus, chronic kidney dence on renal dialysis.</li> <li><i>IDS</i> dated 6/17/16, indicated ly intact, exhibited no mood or s, and required extensive d mobility, transfers, walking</li> </ul>		DEFICIENC		

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00594	B. WING		06/	30/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
LAKESH	IORE INC		NDON ROAD , MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	wait twenty minutes toilet on Saturday, 6 stool running out ar toilet was still dirty f stated he had told r At 8:45 a.m. R111's dark, dried and crus bowl and smeared seat with a small ar of the seat. At 10:29 toilet seat and state by housekeeping of On 6/29/16, at 12:2 embarrassed to hav and it was embarra several days. On 6/30/16, at 8:00 director (ED) stated daily and checked r a health problem su diarrhea. On 6/30/16, at 2:17 resident was knowr afternoon nursing a several times in bet cleanings. The DOI assistants should h they noticed this, ar assistants did clear The facility Quality 6 8/09, directed staff responding to resid assistance. A policy was requested, but	s for assistance when on the 5/25/16. R111 said he had and all over the toilet, and his rom that occurrence. R111 nursing staff his toilet was dirty. toilet was observed to have sted stool on the top of the over most of the bottom of the nount of dried stool on the top 9 a.m. RN-B observed R111's and it should have been cleaned		DEFICIENC	ντ) 	

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED	
		00594	B. WING		06/	06/30/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
LAKESH	ORE INC		NDON ROAD , MN 55804				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21805	Continued From pa	ge 16	21805				
	bathrooms.						
	The Director of Nur develop, review, an procedures to ensu maintained and toil manner. The Director of Nur educate all appropr procedures. The Director of Nur	HOD OF CORRECTION: sing or designee could id/or revise policies and irre resident's dignity is ets are cleaned in a timely sing or designee could riate staff on the policies and rsing or designee could systems to ensure ongoing					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one	•				
21830	MN St. Statute 144 Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights	21830			8/8/16	
	Subd. 10. Particip notification of family	pation in planning treatment; y members.					
	in the planning of the includes the opport alternatives with inco- opportunity to reque- care conferences, a family member or co- both. In the event to present, a family me chosen by the resident we unconscious or cor- communicate, the f	Il have the right to participate neir health care. This right unity to discuss treatment and dividual caregivers, the est and participate in formal and the right to include a other chosen representative or that the resident cannot be ember or other representative lent may be included in such who enters a facility is natose or is unable to facility shall make reasonable under paragraph (c) to notify					

	ota Department of He	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION		E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
	00594		B. WING		06/30/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
	ORE INC	4002 LON	IDON ROAD			
LAKESH		DULUTH,	MN 55804			
(X4) ID			ID	PROVIDER'S PLAN OF COP		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		COMPLET DATE
inte		,		DEFICIENCY)		
21830	Continued From pa	ge 17	21830			
		-				
		ber or a person designated in				
		ent as the person to contact in the resident has been				
		lity. The facility shall allow the				
		articipate in treatment				
		e facility knows or has reason				
		ent has an effective advance				
		trary or knows the resident has				
		that they do not want a family				
		n treatment planning. After				
		notifying a family member but prior to allowing a family member to participate in treatment				
	planning, the facility must make reasonable					
		vith reasonable medical				
		ne if the resident has				
		ce directive relative to the				
		re decisions. For purposes of				
		asonable efforts" include:				
	resident;	e personal effects of the				
	-	e medical records of the				
		session of the facility;				
		ny emergency contact or				
		tacted under this section				
		nt has executed an advance				
		er the resident has a				
		the resident normally goes for				
	care; and	o physician to whom the				
		e physician to whom the oes for care, if known,				
		nt has executed an advance				
		y notifies a family member or				
	designated emerge	ency contact or allows a family				
		ate in treatment planning in				
		s paragraph, the facility is not				
		r damages on the grounds that				
		ne family member or				
		or the participation of the improper or violated the				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00594	B. WING		06/30/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
LAKESH	ORE INC		MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
21830	family member or d the facility shall atter members or a designed examining the pers and the medical rec possession of the fa- to notify a family me emergency contact admission, the facil social service agen agency that the res the facility has beer member or designat county social service enforcement agence identifying and notif designated emerge service agency or la that assists a facility subdivision is not lia damages on the grat the family member participation of the or violated the patien	hts. asonable efforts to notify a lesignated emergency contact, empt to identify family gnated emergency contact by onal effects of the resident cords of the resident in the acility. If the facility is unable ember or designated within 24 hours after the ity shall notify the county cy or local law enforcement ident has been admitted and n unable to notify a family ated emergency contact. The e agency and local law ey shall assist the facility in fying a family member or ency contact. A county social ocal law enforcement agency y in implementing this able to the resident for ounds that the notification of or emergency contact or the family member was improper	21830	Corrected.		
		or resident choices for or 1 of 3 residents (R90) ss.				
		ecord printed on 6/30/16, gnoses included a fracture of				

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00594	B. WING	. WING		30/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE		
AKESH	ORE INC		NDON ROAD , MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From pa	ige 19	21830			
	the right lower leg, chronic kidney dise	a history of falls, severe ase and insomnia.				
	5/22/16, indicated F cognition. R90 did r or rejection of cares incontinent of urine program. R90 need	imum Data Set (MDS) dated R90 had moderately impaired not have psychosis, behaviors s. R90 was frequently but was not on a toileting ded the assistance of two staff ransfers, ambulation, dressing, onal hygiene.				
	her up about 7:00 a earlier to take her v she can go back to awake. R90 stated but they keep doing since she came to on. R90 stated she (NA) that usually go and 7:30 a.m. that 8:00 a.m. R90 stated	a.m. R90 stated staff wake a.m. or sometimes a little ritals. R90 stated they tell her sleep but then she's wide she told someone at the desk g it and it had been happening the facility and it was still going had told the nursing assistant of her up between 7:00 a.m. she did not want to get up until ed the NA was pretty firm up. Nice but firm about what	3			
	get up at 8:00 a.m. conference a week in bed until 8:00 a.r changed. R90 futhe early she liked to st	p.m. R90 reconfirmed liked to and told staff during the care or so ago she wanted to stay n. R90 stated nothing er stated even if she wakes up tay in bed until 8:00 a.m. e to know you have time to le.				
	going from room to NA-B stated this wa vitals. NA-B did not	a.m. NA-B was observed room obtaining resident vitals as the time she usually did the do a resident's vitals this early on the door indicating so.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00594	B. WING		06/3	30/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
LAKESH	ORE INC		NDON ROAD , MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21830	Continued From pa	age 20	21830			
	R90 did not have a	sign on the door.				
	up between 7:15 a. verified R90 had to bed until 8:00 a.m. assisted living. The get up early becaus	a.m. NA-A stated she got R90 m. and 7:20 a.m. NA-A ld her she wanted to stay in but that was her schedule at schedule at the facility was to se of therapy.				
	(OT)-A stated she of around 7:30 a.m. b trying to get up at th incontinent of urine loosing weight while important for R90 to a.m. was the time F	did OT cares with R90 usually ecause R90 had falls while he assisted living, was in the morning and was e at the facility so it was o get up for breakfast. 8:00 R90's caregiver arrived and o not to get up until 8:00				
		a.m. the director of nursing s request to get up at ave been honored.				
	stated she did not h not be awakened o	a.m. registered nurse (RN)-A nave any request from R90 to r gotten up until 8:00 a.m. nts were not asked specifically ited to get up.				
	The facility was una resident choices.	able to provide a policy on				
	Director of Nursing review, and/or revis ensure residents ar routines.	THOD OF CORRECTION: The or designee could develop, se policies and procedures to re given choices with their daily				
		rsing or designee could riate staff on the policies and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00594			06/	30/2016
	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	ATE, ZIP CODE		
AKESH	ORE INC		I, MN 55804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21830	Continued From pa	age 21	21830			
		rsing or designee could systems to ensure ongoing				
	TIME PERIOD FOI (21) Days	R CORRECTION: Twenty One	e			