



*Protecting, Maintaining and Improving the Health of All Minnesotans*

December 29, 2021

Administrator  
Lakeside Generations Assisted  
441 William Avenue East  
Dassel, MN 55325

RE: Project Number(s) SL20568015-1

Dear Administrator:

On November 29, 2021, the Minnesota Department of Health completed a follow-up evaluation of your facility to determine if orders from the September 17, 2021, evaluation were corrected. The follow-up evaluation verified that the facility is in substantial compliance.

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. You are encouraged to retain this document for your records.

Please feel free to call me with any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'J. Cummins'.

Jeri Cummins, Supervisor  
Health Regulation Division  
State Evaluation Team  
85 East Seventh Place, Suite 220  
P.O. Box 3879  
St. Paul, MN 55101-3879  
Telephone: 218-302-6193 Fax: 651-215-9697

pmb



*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically Delivered

October 15, 2021

Administrator  
Lakeside Generations Assisted  
441 William Avenue East  
Dassel, MN 55325

RE: Project Number(s) SL20568015

Dear Administrator:

The Minnesota Department of Health completed an evaluation on September 17, 2021, for the purpose of evaluating and assessing compliance with state licensing statutes. At the time of the evaluation, the Minnesota Department of Health noted violations of the laws pursuant to Minnesota Statute, Chapter 144G, Minnesota Food Code, Minnesota Rules Chapter 4626, Minnesota Statute 626.5572 and/or Minnesota Statute Chapter 260E.

The enclosed State Form documents the state licensing orders. The Department of Health documents state licensing correction orders using federal software. Tag numbers are assigned to Minnesota state statutes for Home Care Providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance are listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN Requirement is not met as evidenced by . . ."

#### **IMPOSITION OF FINES**

In accordance with Minn. Stat. § 144G.31, Subd. 4, fines and enforcement actions may be imposed based on the level and scope of the violations and imposed immediately with no opportunity to correct the violation first as follows:

Level 1: no fines or enforcement.

Level 2: a fine of \$500 per violation, in addition to any enforcement mechanism authorized in § 144G.20 for widespread violations;

Level 3: a fine of \$3,000 per violation per incident, in addition to any enforcement mechanism authorized in § 144G.20.

Level 4: a fine of \$5,000 per incident, in addition to any enforcement mechanism authorized in § 144G.20.

In accordance with Minn. Stat. § 144G.20, Subd. 4 (a)(5), the Department of Health imposes fine amounts of either \$1,000 or \$5,000 to licensees who are found to be responsible for maltreatment. The Department of Health imposes a fine of \$1,000 for each substantiated maltreatment violation

that consists of abuse, neglect, or financial exploitation according to Minn. Stat. § 626.5572. subds. 2, 9, 17. The Department of Health also may impose a fine of \$5,000 for each substantiated maltreatment violation consisting of sexual assault, death, or abuse resulting in serious injury.

In accordance with Minn. Stat. § 144G.31, Subd. 4 (a)(5)(b), immediate fine imposition is authorized for both surveys and investigations conducted. When a fine is assessed against a facility for substantiated maltreatment, the commissioner shall not also impose an immediate fine under this chapter for the same circumstance.

Therefore, in accordance with Minn. Stat. §§ 144G.01 to 144G.9999, the following fines are assessed pursuant to this evaluation:

**St - 0 - 0510 - 144g.41 Subd. 3 - Infection Control Program - \$500.00**

**The total amount you are assessed is \$500.00.** You will be invoiced after 15 days of the receipt of this notice, subject to appeal.

**DOCUMENTATION OF ACTION TO COMPLY**

Per Minn. Stat. § 144G.30, Subd. 5(c), the licensee must document any action taken to comply with the correction order. A copy of the provider's records documenting those actions may be requested for follow-up surveys. The licensee is not required to submit a plan of correction for approval.

The correction order documentation should include the following:

- Identify how the area(s) of noncompliance was corrected related to the client(s)/employee(s) identified in the correction order.
- Identify how the area(s) of noncompliance was corrected for all of the provider's clients/employees that may be affected by the noncompliance.
- Identify what changes to your systems and practices were made to ensure compliance with the specific statute(s).

**CORRECTION ORDER RECONSIDERATION PROCESS**

In accordance with Minn. Stat. § 144G.32, Subd. 2, you may challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. The request for reconsideration must be in writing and received by the Department of Health within 15 calendar days.

A state licensing order under Minn. Stat. § 144G.91, Subd. 8, Free from Maltreatment is associated with a maltreatment determination by the Office of Health Facility Complaints. If maltreatment is substantiated, you will receive a separate letter with the reconsideration process under Minn. Stat. § 626.557. Please email general reconsideration requests to: **Health.HRD.Appeals@state.mn.us**.

Please address your cover letter for general  
reconsideration requests to:

Reconsideration Unit  
Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64970  
85 East Seventh Place  
St. Paul, MN 55164-0970

Free from Maltreatment reconsideration  
requests should addressed to:

Reconsideration Unit  
Health Regulation Division  
Minnesota Department of Health  
P.O. Box 64970  
85 East Seventh Place  
St. Paul, MN 55164-0970

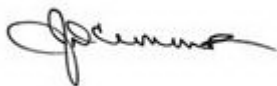
### REQUESTING A HEARING

Alternatively, in accordance with Minn. Stat. § 144G.31, Subd. 5(d), an assisted living provider that has been assessed a fine under this subdivision has a right to a reconsideration or a hearing under this section and chapter 14. Pursuant to Minn. Stat. § 144G.20, Subd. 14, a request for a hearing must be in writing and received by the Department of Health within 15 calendar days. Requests for hearing may be emailed to **Health.HRD.Appeals@state.mn.us**.

To appeal fines via reconsideration, please follow the procedure outlined above. Please note that you may request a reconsideration **or** a hearing, but not both.

You are encouraged to retain this document for your records. It is your responsibility to share the information contained in this letter and the results of this visit with the President of your organization's Governing Body. If you have any questions, please contact me.

Sincerely,



Jeri Cummins, Supervisor  
Health Regulation Division  
State Evaluation Team  
85 East Seventh Place, Suite 220  
P.O. Box 3879  
St. Paul, MN 55101-3879  
Email: [jeri.cummins@state.mn.us](mailto:jeri.cummins@state.mn.us)  
Telephone: 218-302-6193 Fax: 651-215-9697

HHH

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                        |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X5)<br>COMPLETE<br>DATE                               |
| 0 000                                                                    | <p>Initial Comments</p> <p>Initial comments<br/>*****ATTENTION*****</p> <p>ASSISTED LIVING LICENSING CORRECTION<br/>ORDER(S)</p> <p>In accordance with Minnesota Statutes, section<br/>144G.08 to 144G.95, these correction orders are<br/>issued pursuant to a survey.</p> <p>Determination of whether violations are corrected<br/>requires compliance with all requirements<br/>provided at the Statute number indicated below.<br/>When Minnesota Statute contains several items,<br/>failure to comply with any of the items will be<br/>considered lack of compliance.</p> <p>INITIAL COMMENTS:<br/>SL#20568015</p> <p>On September 15, 2021 through September 17,<br/>2021, the Minnesota Department of Health<br/>conducted a survey at the above provider, and<br/>the following correction orders are issued. At the<br/>time of the survey, there were 31 residents<br/>receiving services under the provider's Assisted<br/>Living license.</p> | 0 000                                                                                        | <p>Minnesota Department of Health is<br/>documenting the State Licensing<br/>Correction Orders using federal software.<br/>Tag numbers have been assigned to<br/>Minnesota State Statutes for Assisted<br/>Living License Providers. The assigned<br/>tag number appears in the far left column<br/>entitled "ID Prefix Tag." The state Statute<br/>number and the corresponding text of the<br/>state Statute out of compliance is listed in<br/>the "Summary Statement of Deficiencies"<br/>column. This column also includes the<br/>findings which are in violation of the state<br/>requirement after the statement, "This<br/>Minnesota requirement is not met as<br/>evidenced by." Following the surveyors'<br/>findings is the Time Period for Correction.</p> <p>PLEASE DISREGARD THE HEADING OF<br/>THE FOURTH COLUMN WHICH<br/>STATES,"PROVIDER'S PLAN OF<br/>CORRECTION." THIS APPLIES TO<br/>FEDERAL DEFICIENCIES ONLY. THIS<br/>WILL APPEAR ON EACH PAGE.</p> <p>THERE IS NO REQUIREMENT TO<br/>SUBMIT A PLAN OF CORRECTION FOR<br/>VIOLATIONS OF MINNESOTA STATE<br/>STATUTES.</p> <p>THE LETTER IN THE LEFT COLUMN IS<br/>USED FOR TRACKING PURPOSES AND<br/>REFLECTS THE SCOPE AND LEVEL<br/>ISSUED PURSUANT TO 144G.31<br/>SUBDIVISION 1-3.</p> |                                                        |
| 0 480<br>SS=F                                                            | 144G.41 Subd 1 (13) (i) (B) Minimum<br>requirements                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | 0 480                                                                                        |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                        |

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

TITLE

(X6) DATE

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 480                                                                    | <p>Continued From page 1</p> <p>(13) offer to provide or make available at least the following services to residents:</p> <p>(i) at least three nutritious meals daily with snacks available seven days per week, according to the recommended dietary allowances in the United States Department of Agriculture (USDA) guidelines, including seasonal fresh fruit and fresh vegetables. The following apply:</p> <p>(B) food must be prepared and served according to the Minnesota Food Code, Minnesota Rules, chapter 4626; and</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to ensure food was prepared according to the Minnesota Food Code. This had the potential to affect the licensee's 31 current residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>Please refer to the additional documentation</p> | 0 480                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 480                                                                    | Continued From page 2<br><br>included in the Food and Beverage Establishment<br>Inspection Reports, dated September 16, 2021.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 0 480                                                                                        |                                                                                                                          |                                                        |
| 0 510<br>SS=F                                                            | 144G.41 Subd. 3 Infection control program<br><br>(a) All assisted living facilities must establish and<br>maintain an infection control program that<br>complies with accepted health care, medical, and<br>nursing standards for infection control.<br>(b) The facility's infection control program must be<br>consistent with current guidelines from the<br>national Centers for Disease Control and<br>Prevention (CDC) for infection prevention and<br>control in long-term care facilities and, as<br>applicable, for infection prevention and control in<br>assisted living facilities.<br>(c) The facility must maintain written evidence of<br>compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview and record<br>review, the licensee failed to establish and<br>maintain an infection control program that<br>complies with accepted health care, medical and<br>nursing standards for infection control. This had<br>the potential to affect all 31 residents and staff.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or<br>safety but had the potential to have harmed a<br>resident's health or safety) and was issued at a<br>widespread scope (when problems are pervasive<br>or represent a systemic failure that has affected<br>or has the potential to affect a large portion or all<br>the residents). | 0 510                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 510                                                                    | <p>Continued From page 3</p> <p>The findings include:</p> <p><b>PERSONAL PROTECTIVE EQUIPMENT (PPE)</b></p> <p>The MDH guidance titled, "COVID-19 Toolkit," dated March 8, 2021, noted all staff should wear eye protection (face shield, goggles) when in resident care areas. All staff should always wear a well-fitting medical grade face mask. The use of appropriate PPE can reduce staff exposures that might occur before detection of a COVID-19 case that might lead to exclusion from work.</p> <p>The MDH guidance titled, "COVID-19 Personal Protective Equipment Grid for Home-Care and Hospice Settings," dated April 23, 2021, noted healthcare workers with face-to-face contact with COVID-19 negative clients should wear a medical grade well-fitting face mask and eye protection.</p> <p>On September 16, 2021, at approximately 6:00 a.m., unlicensed personnel (ULP)-F and ULP-G were observed in the nurses' station standing in front of a medication cart. ULP-F and ULP-G were in the process of conducting a shift-to-shift narcotic count. ULP-F and ULP-G were not wearing face masks. ULP-F and ULP-G were observed standing within six feet of each other.</p> <p>On September 16, 2021, at approximately 11:15 a.m., registered nurse (RN)-B confirmed face masks are to be worn.</p> <p>The licensee's COVID-19 PROTOCOL policy dated September 17, 2020, verified all employees entering the facility would wear appropriate PPE, including a surgical mask.</p> <p><b>DISINFECTING EQUIPMENT BETWEEN USE</b></p> | 0 510                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 510                                                                    | Continued From page 4<br><br>ULP-F failed to ensure infection control standards were followed with regards to disinfecting reusable resident equipment.<br><br>On September 16, 2021, at approximately 6:25 a.m., ULP-F was observed placing a SpO2 monitor onto one of resident (R)2's fingers. ULP-F did not disinfect the SpO2 monitor prior to or after equipment use. ULP-F did not disinfect the SpO2 monitor or the blood pressure cuff prior to or after equipment use.<br><br>On September 16, 2021, at approximately 6:35 a.m., ULP-F was observed placing a SpO2 monitor onto one of R1's fingers. ULP-F was observed placing a blood pressure cuff on R1's upper arm. ULP-F did not disinfect the SpO2 monitor or the blood pressure cuff prior to or after equipment use.<br><br>On September 16, 2021, at approximately 7:10 a.m., RN-A confirmed equipment should be cleaned after each use.<br><br>The licensee's Standard Precautions (Universal Precautions) policy dated March 14, 2019, confirmed reusable equipment would be appropriately cleaned and reprocessed prior to use on another resident.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Two (2) days | 0 510                                                                                        |                                                                                                                          |                                                        |
| 0 550<br>SS=F                                                            | 144G.41 Subd. 7 Resident grievances; reporting maltreatment                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 0 550                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 550                                                                    | <p>Continued From page 5</p> <p>All facilities must post in a conspicuous place information about the facilities' grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. The notice must also have the contact information for the state and applicable regional Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities, and must have information for reporting suspected maltreatment to the Minnesota Adult Abuse Reporting Center.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to post in a conspicuous place information about the facility's grievance procedure, and the name, telephone number, and e-mail contact information for the individuals who are responsible for handling resident grievances. This had the potential to affect all 31 residents receiving assisted living services, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>On September 15, 2021, at approximately 10:30 a.m. during a facility tour, the licensed assisted living director (LALD)-C showed surveyors a</p> | 0 550                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 550                                                                    | Continued From page 6<br><br>communication board where information regarding the facility grievance procedure was located. The posted grievance informational statement did not include the the name, telephone number, and e-mail contact information for the individuals who were responsible for handling resident grievances.<br><br>On September 15, 2021, at approximately 10:45 LALD-C confirmed the statement did not to include all the required information.<br><br>The licensee's Complaint-Grievance procedure-MN policy reviewed on June 4, 2021, failed to include the new Assisted Living Licensure requirements that went into effect August 1, 2021.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days | 0 550                                                                                        |                                                                                                                          |                                                        |
| 0 640<br>SS=F                                                            | 144G.42 Subd. 7 Posting information for reporting suspected c<br><br>The facility shall support protection and safety through access to the state's systems for reporting suspected criminal activity and suspected vulnerable adult maltreatment by:<br>(1) posting the 911 emergency number in common areas and near telephones provided by the assisted living facility;<br>(2) posting information and the reporting number for the Minnesota Adult Abuse Reporting Center to report suspected maltreatment of a vulnerable adult under section 626.557; and<br>(3) providing reasonable accommodations with information and notices in plain language.                                                                                                               | 0 640                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 640                                                                    | <p>Continued From page 7</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to support protection and safety by not posting information and phone numbers to include 911 in common areas and near telephones provided by the assisted living facility. This had the potential to affect all 31 residents receiving assisted living care services, staff, and visitors.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>On September 15, 2021, at approximately 10:30 a.m., during a facility tour, the licensed assisted living director (LALD)-C showed surveyors a communication board where information regarding vulnerable adult laws/ abuse prevention procedure was located. The posted information did not include the telephone number 911. In addition, no telephones provided by the facility were located for resident use in the commons area.</p> <p>On September 15, 2021, at approximately 10:40 a.m., LALD-C confirmed "911" was not included in the information posted regarding vulnerable adults.</p> | 0 640                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 640                                                                    | Continued From page 8<br><br>The licensee's policy, "Abuse Prohibition-AL-MN,<br>dated June 4, 2021, did not include the new<br>Assisted Living Licensure requirements related to<br>posting of the adult abuse reporting emergency<br>numbers.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7)<br>days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 0 640                                                                                        |                                                                                                                          |                                                        |
| 0 660<br>SS=F                                                            | 144G.42 Subd. 9 Tuberculosis prevention and<br>control<br><br>(a) The facility must establish and maintain a<br>comprehensive tuberculosis infection control<br>program according to the most current<br>tuberculosis infection control guidelines issued by<br>the United States Centers for Disease Control<br>and Prevention (CDC), Division of Tuberculosis<br>Elimination, as published in the CDC's Morbidity<br>and Mortality Weekly Report. The program must<br>include a tuberculosis infection control plan that<br>covers all paid and unpaid employees,<br>contractors, students, and regularly scheduled<br>volunteers. The commissioner shall provide<br>technical assistance regarding implementation of<br>the guidelines.<br>(b) The facility must maintain written evidence of<br>compliance with this subdivision.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on interview and record review, the<br>licensee failed to establish and maintain a<br>tuberculosis (TB) prevention program based on<br>the most current guidelines issued by the Centers<br>for Disease Control and Prevention (CDC) which<br>included a facility TB risk assessment. | 0 660                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 660                                                                    | <p>Continued From page 9</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and is issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all of the residents).</p> <p>The findings include:</p> <p>During the entrance conference on September 15, 2021, at approximately 10:13 a.m., with director of clinical services and registered nurse (RN)-B, a request was made to review the facility TB risk assessment. RN-B stated a facility TB risk assessment had been completed "sometime in 2019," but the licensee did not have a recent TB risk assessment completed.</p> <p>On September 15, 2021, at approximately 3:15 p.m., a TB risk assessment dated May 6, 2019, was produced.</p> <p>The Minnesota Department of Health (MDH) guidelines, Regulations for Tuberculosis Control in Minnesota Health Care Settings, dated July 2013, and based on CDC guidelines, indicated a TB infection control program should include a facility TB risk assessment.</p> <p>The licensee's TB Prevention and Screening AL-MN policy revised date January 8, 2021, indicated a TB risk assessment using the MDH risk assessment worksheet will be completed every two years per MDH guidelines.</p> <p>No further information was provided.</p> | 0 660                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 660                                                                    | Continued From page 10                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 0 660                                                                                        |                                                                                                                          |                                                        |
|                                                                          | TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                          |                                                        |
| 0 680<br>SS=F                                                            | 144G.42 Subd. 10 Disaster planning and<br>emergency preparedness<br><br>(a) The facility must meet the following<br>requirements:<br>(1) have a written emergency disaster plan that<br>contains a plan for evacuation, addresses<br>elements of sheltering in place, identifies<br>temporary relocation sites, and details staff<br>assignments in the event of a disaster or an<br>emergency;<br>(2) post an emergency disaster plan prominently;<br>(3) provide building emergency exit diagrams to<br>all residents;<br>(4) post emergency exit diagrams on each floor;<br>and<br>(5) have a written policy and procedure regarding<br>missing tenant residents.<br>(b) The facility must provide emergency and<br>disaster training to all staff during the initial staff<br>orientation and annually thereafter and must<br>make emergency and disaster training annually<br>available to all residents. Staff who have not<br>received emergency and disaster training are<br>allowed to work only when trained staff are also<br>working on site.<br>(c) The facility must meet any additional<br>requirements adopted in rule.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on interview and record review, the<br>licensee failed to develop a written plan of action<br>to facilitate the management of the residents | 0 680                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                                    | <p>Continued From page 11</p> <p>care and services in response to a disaster or other emergencies that may disrupt the licensee's ability to provide care and services. This has the potential to affect all residents and staff.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).</p> <p>The findings include:</p> <p>The licensee's disaster and emergency plan failed to include the required content:</p> <p>-</p> <p>On September 16, 2021, at approximately 3:30 p.m. during an interview regarding disaster planning, licensed assisted living director (LALD)-C motioned with her hand to a general area outside of the building near a tree to indicate where residents and staff would meet in the event of an evacuation of the facility. There was no system in place for evacuation or how the building was to be evacuated.</p> <p>On September 16, 2021, at approximately 3:55 p.m. maintenance supervisor (MS)-D confirmed there was no evidence of weekly testing of all exit door alarms and locks as directed by the licensee's policy.</p> <p>On September 16, 2021, at approximately 4:00 p.m. LALD-C confirmed the disaster planning and emergency preparedness "was in process."</p> <p>The licensee's Evacuation Plan reviewed/revised</p> | 0 680                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 680                                                                    | Continued From page 12<br><br>July 1, 2021, failed to include a tracking system<br>for residents and staff.<br><br>The licensee's Missing Resident Plan reviewed<br>July 1, 2021, verified "all sites would have specific<br>prevention protocols in place related to any<br>incident of elopement and/or missing resident."<br><br>The licensee's Exit Door Alarms/Locks, Elevator<br>Alarms (Wandergard or other similar product)<br>policy dated November 22, 2019, confirmed all<br>exit door alarms and locks would be tested<br>weekly and as needed per manufacturer's<br>instructions.<br><br>In addition, the licensee's emergency<br>preparedness binder did not contain a policy<br>pertaining to volunteers.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one<br>(21) days | 0 680                                                                                        |                                                                                                                          |                                                        |
| 0 780<br>SS=F                                                            | 144G.45 Subd. 2 (a) (1) Fire protection and<br>physical environment<br><br>(a) Each assisted living facility must comply with<br>the State Fire Code in Minnesota Rules, chapter<br>7511, and:<br><br>(1) for dwellings or sleeping units, as defined in<br>the State Fire Code:<br>(i) provide smoke alarms in each room used<br>for sleeping purposes;<br>(ii) provide smoke alarms outside each<br>separate sleeping area in the immediate vicinity<br>of bedrooms;<br>(iii) provide smoke alarms on each story                                                                                                                                                                                                                                                                                                              | 0 780                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 780                                                                    | <p>Continued From page 13</p> <p>within a dwelling unit, including basements, but not including crawl spaces and unoccupied attics;<br/>(iv) where more than one smoke alarm is required within an individual dwelling unit or sleeping unit, interconnect all smoke alarms so that actuation of one alarm causes all alarms in the individual dwelling unit or sleeping unit to operate; and<br/>(v) ensure the power supply for existing smoke alarms complies with the State Fire Code, except that newly introduced smoke alarms in existing buildings may be battery operated;</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation and interview, the facility failed to provide smoke detectors in the rooms used for sleeping purposes. This has the potential to affect all residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br/>The findings include:<br/>On September 16, 2021, between 9:50 a.m. and 10:25 a. m., during a facility wide tour conducted with maintenance supervisor (MS)-D and a maintenance staff member (MSM)-E, observation was made that smoke detectors were not located in rooms used for sleeping purposes.</p> <p>On September 16, 2021, at approximately 10:20 a.m., MS-D and MSM-E confirmed smoke detectors were not placed in all rooms used for sleeping purposes.</p> | 0 780                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 780                                                                    | Continued From page 14<br><br>The licensee did not have policies to include the new Assisted Living Licensure requirements, that went into effect August 1, 2021.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | 0 780                                                                                        |                                                                                                                          |                                                        |
| 0 810<br>SS=F                                                            | 144G.45 Subd. 2 (b)-(f) Fire protection and physical environment<br><br>(b) Each assisted living facility shall develop and maintain fire safety and evacuation plans. The plans shall include but are not limited to:<br>(1) location and number of resident sleeping rooms;<br>(2) employee actions to be taken in the event of a fire or similar emergency;<br>(3) fire protection procedures necessary for residents; and<br>(4) procedures for resident movement, evacuation, or relocation during a fire or similar emergency including the identification of unique or unusual resident needs for movement or evacuation.<br>(c) Employees of assisted living facilities shall receive training on the fire safety and evacuation plans upon hiring and at least twice per year thereafter.<br>(d) Fire safety and evacuation plans shall be readily available at all times within the facility.<br>(e) Residents who are capable of assisting in their own evacuation shall be trained on the proper actions to take in the event of a fire to include movement, evacuation, or relocation. The training shall be made available to residents at least once per year. | 0 810                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 0 810                                                                    | <p>Continued From page 15</p> <p>(f) Evacuation drills are required for employees twice per year per shift with at least one evacuation drill every other month. Evacuation of the residents is not required. Fire alarm system activation is not required to initiate the evacuation drill.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on interview and record review, the facility failed to ensure a training schedule and policies were in place for residents who are capable of assisting in their own evacuation. This has the potential to affect all residents.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at a widespread scope (when problems are pervasive or represent a systemic failure that has affected or has the potential to affect a large portion or all the residents).<br/>The findings include:<br/>On September 16, 2021, between 9:50 a.m., and 10:25 a.m., a review of the facility records was conducted with the maintenance supervisor (MS-D) and a maintenance staff member (MSM-E) regarding the fire safety and evacuation training.</p> <p>On September 16, 2021, at approximately 10:20 a.m., MS-D and MSM-E confirmed the facility has no policy or training in place for the residents at this time.</p> <p>No further information was provided.</p> <p>No TIME PERIOD FOR CORRECTION:<br/>Twenty-one (21) days</p> | 0 810                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01440<br>SS=D                                                            | <p>144G.62 Subd. 4 Supervision of staff providing delegated nurs</p> <p>(a) Staff who perform delegated nursing or therapy tasks must be supervised by an appropriate licensed health professional or a registered nurse according to the assisted living facility's policy where the services are being provided to verify that the work is being performed competently and to identify problems and solutions related to the staff person's ability to perform the tasks. Supervision of staff performing medication or treatment administration shall be provided by a registered nurse or appropriate licensed health professional and must include observation of the staff administering the medication or treatment and the interaction with the resident.</p> <p>(b) The direct supervision of staff performing delegated tasks must be provided within 30 calendar days after the date on which the individual begins working for the facility and first performs the delegated tasks for residents and thereafter as needed based on performance. This requirement also applies to staff who have not performed delegated tasks for one year or longer.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview and record review, the licensee failed to ensure the registered nurse (RN) conducted direct supervision of staff performing delegated nursing or therapy tasks within 30 days of first providing those services for one of two unlicensed personnel (ULP)-F with employee records reviewed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or</p> | 01440                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01440                                                                    | <p>Continued From page 17</p> <p>safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>ULP-F had a hire date of August 1, 2021.</p> <p>On September 16, 2021, at approximately 6:35 a.m. ULP-F was observed placing a SpO2 (oximeter) monitor onto one of R1's fingers. ULP-F was observed placing a blood pressure cuff on R1's upper arm.</p> <p>R1's treatment record for September 1 to 15, 2021, indicated ULP-F had performed SpO2 readings on multiple occasions to R1.</p> <p>On September 16, 2021, at approximately 3:30 p.m. director of clinical services/registered nurse (RN)-B verified ULP-F's employee record had no evidence ULP-F was supervised after performing delegated nursing or therapy tasks within 30 calendar days after first providing those services.</p> <p>The licensee's Supervision of Unlicensed Personnel-AL policy dated June 29, 2021, indicated the direct supervision of staff performing delegated tasks must be provided within 30-days after the date on which the individual begins working for the assisted living and first performs the delegated tasks for residents.</p> <p>No further information was provided.</p> | 01440                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01440                                                                    | Continued From page 18<br><br>TIME PERIOD FOR CORRECTION: Twenty-One<br>(21) days                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 01440                                                                                        |                                                                                                                          |                                                        |
| 01640<br>SS=D                                                            | 144G.70 Subd. 4 Service plan, implementation,<br>and revisions t<br><br>(a) No later than 14 calendar days after the date<br>that services are first provided, an assisted living<br>facility shall finalize a current written service plan.<br>(b) The service plan and any revisions must<br>include a signature or other authentication by the<br>facility and by the resident documenting<br>agreement on the services to be provided. The<br>service plan must be revised, if needed, based on<br>resident reassessment under subdivision 2. The<br>facility must provide information to the resident<br>about changes to the facility's fee for services<br>and how to contact the Office of Ombudsman for<br>Long-Term Care.<br>(c) The facility must implement and provide all<br>services required by the current service plan.<br>(d) The service plan and the revised service plan<br>must be entered into the resident record,<br>including notice of a change in a resident's fees<br>when applicable.<br>(e) Staff providing services must be informed of<br>the current written service plan.<br><br>This MN Requirement is not met as evidenced<br>by:<br>Based on observation, interview and record<br>review, the licensee failed to ensure the service<br>plan was revised to include all services being<br>provided for two of three residents (R1, R2) with<br>records reviewed.<br><br>This practice resulted in a level two violation (a<br>violation that did not harm a resident's health or | 01640                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01640                                                                    | <p>Continued From page 19</p> <p>safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).<br/>The findings include:<br/>R1<br/>R1's diagnoses included, but were not limited to, diabetes and hypertension (high blood pressure.)</p> <p>R1's Physician Order Report dated March 23, 2021, included order for blood pressure check daily.</p> <p>R1's Service Plan dated July 31, 2021, failed to include the service of medication administration and on going health monitoring, (blood pressure).</p> <p>R1's Medication Administration Record (MAR) dated September 1 through September 15, 2021, confirmed medication administration and daily blood pressure monitoring were services provided.</p> <p>On September 16, 2021, at approximately 6:35 a.m., unlicensed personal (ULP)-F was observed administering medication and completing blood pressure monitoring for R1.</p> <p>On September 16, 2021, at approximately 10:40 a.m., director of clinical services/registered nurse (RN)-B confirmed R1's service plan did not contain all the services provided to R1.</p> <p>R2<br/>R2's diagnoses included, but were not limited to, Parkinson's disease (a long-term degenerative</p> | 01640                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01640                                                                    | <p>Continued From page 20</p> <p>disorder of the central nervous system that mainly affects the motor system), benign prostatic hyperplasia with lower urinary tract symptoms (enlargement of the prostate gland that can cause urination difficulty) and diabetes.</p> <p>R2's Service Plan with Schedule dated July 28, 2021, failed to include medication administration and on going health monitoring (weight).</p> <p>R2's Physician Order Report dated April 11, 2021, through May 11, 2021, included an order for daily weight.</p> <p>R2's MAR dated September 1 through September 15, 2021, confirmed medication administration and daily blood pressure monitoring were provided.</p> <p>On September 16, 2021, at approximately 6:25 a.m., ULP-F was observed administering medication, emptying a catheter leg bag, and obtaining a weight for R2.</p> <p>On September 16, 2021, at approximately 11:40 a.m., RN-B confirmed R2's service plan did not contain all the services provided to R2.</p> <p>The licensee's Service Plan Contents dated August 1, 2021, confirmed all assisted living residents should have an up-to-date service plan identifying services provided.</p> <p>No further information provided.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p> | 01640                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01750                                                                    | Continued From page 21                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 01750                                                                                        |                                                                                                                          |                                                        |
| 01750<br>SS=D                                                            | <p>144G.71 Subd. 7 Delegation of medication administration</p> <p>When administration of medications is delegated to unlicensed personnel, the assisted living facility must ensure that the registered nurse has:</p> <p>(1) instructed the unlicensed personnel in the proper methods to administer the medications, and the unlicensed personnel has demonstrated the ability to competently follow the procedures;</p> <p>(2) specified, in writing, specific instructions for each resident and documented those instructions in the resident's records; and</p> <p>(3) communicated with the unlicensed personnel about the individual needs of the resident.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to provide specific resident instructions relating to the administration of medications for one of three residents (R1) with records reviewed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety, but was not likely to cause serious injury, impairment, or death), and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>The registered nurse (RN) failed to provide specific instructions regarding when to contact the RN for R1 and R2.</p> | 01750                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01750                                                                    | <p>Continued From page 22</p> <p>R1<br/>R1's diagnoses included, but were not limited to,<br/>diabetes and hypertension (high blood pressure).</p> <p>R1's Physician Order Sheet dated March 26,<br/>2021, included but was not limited to:<br/>-"take before giving medication/blood pressure<br/>check" (lacked any specific resident instruction);<br/>-Novolog (insulin)-<br/>*7:00 inject 6 units/U subcutaneous<br/>injection/sub-Q (administer into the layer of skin<br/>directly below the dermis and epidermis) every<br/>morning with a meal;<br/>*11:30 a.m. inject 8 U sub-Q once daily at noon<br/>with a meal; and<br/>*5:00 p.m., inject 9 U sub-Q every evening with a<br/>meal.</p> <p>R1's Individualized Medication Management<br/>dated July 31, 2021, indicated "directions for<br/>administering, monitoring, and documenting<br/>medications would be listed in the electronic<br/>medication record/EMAR."</p> <p>On September 16, 2021, at approximately 6:35<br/>a.m., unlicensed personal (ULP)-F was observed<br/>administering medication and obtaining R1's<br/>blood pressure</p> <p>R1's Medication Administration Record (MAR)<br/>dated September 1, 2021, through September 15,<br/>2021, identified R1 had blood pressure ranges<br/>from 106/67 to 170/124 and blood glucose<br/>ranges from 62-395.</p> <p>On September 15, 2021, at approximately 5:00<br/>p.m., director of clinical services/registered nurse<br/>(RN)-B confirmed R1's record did not contain<br/>specific instructions regarding when staff should<br/>notify the nurse of blood pressure or glucose</p> | 01750                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01750                                                                    | Continued From page 23<br><br>readings.<br><br>The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, verified specific instructions for each "client" would be in the "client's record."<br><br>The licensee's Change in Condition-AL policy, dated November 20, 2019, verified staff must immediately notify the nurse when there was a significant change in condition to include change in vitals signs from general guidelines, blood pressure less than 120 or greater than systolic (heart rate when heart is at work) or less than 60 or greater than diastolic (heart rate when heart is at rest).<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days | 01750                                                                                        |                                                                                                                          |                                                        |
| 01940<br>SS=D                                                            | 144G.72 Subd. 3 Individualized treatment or therapy management<br><br>For each resident receiving management of ordered or prescribed treatments or therapy services, the assisted living facility must prepare and include in the service plan a written statement of the treatment or therapy services that will be provided to the resident. The facility must also develop and maintain a current individualized treatment and therapy management record for each resident which must contain at least the following:<br>(1) a statement of the type of services that will be provided;<br>(2) documentation of specific resident instructions relating to the treatments or therapy                                   | 01940                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01940                                                                    | <p>Continued From page 24</p> <p>administration;<br/>(3) identification of treatment or therapy tasks that will be delegated to unlicensed personnel;<br/>(4) procedures for notifying a registered nurse or appropriate licensed health professional when a problem arises with treatments or therapy services; and<br/>(5) any resident-specific requirements relating to documentation of treatment and therapy received, verification that all treatment and therapy was administered as prescribed, and monitoring of treatment or therapy to prevent possible complications or adverse reactions. The treatment or therapy management record must be current and updated when there are any changes.</p> <p>This MN Requirement is not met as evidenced by:<br/>Based on observation, interview, and record review, the licensee failed to develop an individualized treatment or therapy management plan with the required content for one of three residents (R2) with records reviewed.</p> <p>This practice resulted in a level two violation (a violation that did not harm a resident's health or safety but had the potential to have harmed a resident's health or safety) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved, or the situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R2's diagnoses included, but were not limited to, Parkinson's disease (a long-term degenerative disorder of the central nervous system that mainly affects the motor system), benign prostatic</p> | 01940                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01940                                                                    | <p>Continued From page 25</p> <p>hyperplasia with lower urinary tract symptoms (enlargement of the prostate gland that can cause urination difficulty) and diabetes.</p> <p>R2's record failed to include evidence of a written individualized treatment or therapy management plan for blood glucose testing (pricking a finger with a small, sharp needle, (lancet) to acquire a drop of blood to apply to a test strip;) and catheter care (suprapubic-type of catheter that is left in place, inserted through a hole in abdomen and then directly into the bladder).</p> <p>R2's Physician Order Report dated April 11, 2021, through May 11, 2021, included but was not limited to;</p> <ul style="list-style-type: none"> <li>-blood sugar check once a day, 6:00 a.m.;</li> <li>-FreeStyle Lite Strips (blood sugar diagnostic) strip, 1 strip, every day, 6:00 a.m.;</li> <li>-alcohol swabs pads, medication, topical;</li> <li>-catheter care, once a day, 5:00 a.m.; and</li> <li>-weight, once a day, 7:00 a.m.</li> </ul> <p>On September 16, 2021, at approximately 6:25 a.m., unlicensed personnel (ULP)-F was observed administering medication, emptying a catheter leg bag, and obtaining a weight for R2.</p> <p>On September 16, 2021, at approximately 7:10 a.m., clinical nurse specialist/registered nurse (RN)-A confirmed R2 did not have an individualized treatment plan.</p> <p>The licensee's Treatment or Therapy Services-AL policy dated August 7, 2019, confirmed the nurse would create a written, individualized Therapy/Treatment Plan with the resident and/or responsible part. The Therapy/Treatment Plan would include;</p> <p>a. The type of service to be provided;</p> | 01940                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01940                                                                    | Continued From page 26<br><br>b. Instructions specific to the resident, relating to the treatment or therapy to be administered;<br>c. Identification of specific tasks that would be delegated to unlicensed staff;<br>d. Procedures for notifying the nurse or appropriate healthcare professional if a problem arises with the therapy or treatment service; and<br>e. Any client-specific requirements related to documentation of therapy or treatment received, verification that service was received, and monitoring of therapy or treatment to prevent complications or adverse reactions.<br><br>No further information was provided.<br><br>TIME PERIOD FOR CORRECTION: Seven (7) days.                                                                                                                                                                                                                                  | 01940                                                                                        |                                                                                                                          |                                                        |
| 01950<br>SS=D                                                            | 144G.72 Subd. 4 Administration of treatments and therapy<br><br>Ordered or prescribed treatments or therapies must be administered by a nurse, physician, or other licensed health professional authorized to perform the treatment or therapy, or may be delegated or assigned to unlicensed personnel by the licensed health professional according to the appropriate practice standards for delegation or assignment. When administration of a treatment or therapy is delegated or assigned to unlicensed personnel, the facility must ensure that the registered nurse or authorized licensed health professional has:<br>(1) instructed the unlicensed personnel in the proper methods with respect to each resident and the unlicensed personnel has demonstrated the ability to competently follow the procedures;<br>(2) specified, in writing, specific instructions for each resident and documented those instructions | 01950                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01950                                                                    | <p>Continued From page 27</p> <p>in the resident's record; and<br/>(3) communicated with the unlicensed personnel<br/>about the individual needs of the resident.</p> <p>This MN Requirement is not met as evidenced<br/>by:<br/>Based on interview and record review, the<br/>licensee failed to ensure the registered nurse<br/>(RN) supplied the unlicensed personnel (ULP)<br/>specific instructions for each resident treatments<br/>and/or therapies and documented those<br/>instructions in the resident's record for two of<br/>three residents (R1, R2 ) with records reviewed.</p> <p>This practice resulted in a level two violation (a<br/>violation that did not harm a resident's health or<br/>safety but had the potential to have harmed a<br/>resident's health or safety, but was not likely to<br/>cause serious injury, impairment, or death), and<br/>was issued at an isolated scope (when one or a<br/>limited number of residents are affected or one or<br/>a limited number of staff are involved or the<br/>situation has occurred only occasionally).</p> <p>The findings include:</p> <p>R1<br/>R1's diagnoses included, but were not limited to,<br/>diabetes and hypertension (high blood pressure).</p> <p>R1's Physician Order Sheet authenticated March<br/>26, 2021, included:<br/>- order: "Blood Glucose Testing-continuous-6 AM,<br/>11 AM, 2 PM, 4:15 PM, 7 PM, Indicated for Type<br/>2 diabetes mellitus."</p> <p>R1's Medication Administration record (MAR)<br/>dated September 1, 2021, through September 15,<br/>2021, included:<br/>-"Order: Blood Glucose Testing Other Test;</p> | 01950                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01950                                                                    | <p>Continued From page 28</p> <p>-Frequency: Four Times a Day;<br/>-Special Instructions was left blank,</p> <p>R1's MAR dated September 1, 2021, through September 15, 2021, included: blood glucose ranges from 62-395.</p> <p>On September 15, 2021, at approximately 5:00 p.m., director of clinical services/registered nurse (RN)-B confirmed R1's records did not contain specific instructions for blood glucose monitoring.</p> <p>On September 16, 2021, at approximately 6:25 a.m., unlicensed personnel (ULP)-F was observed administering medication and checking R1's blood glucose.</p> <p>R2<br/>R2's diagnoses included, but were not limited to, Parkinson's disease (a long-term degenerative disorder of the central nervous system that mainly affects the motor system), benign prostatic hyperplasia with lower urinary tract symptoms (enlargement of the prostate gland that can cause urination difficulty) and diabetes.</p> <p>On September 16, 2021, at approximately 6:25 a.m., ULP-F was observed administering medication and obtaining a weight for R2.</p> <p>R2's Physician Order Report dated April 11, 2021, through May 11, 2021, included but was not limited to;<br/>-blood sugar check daily at 6:00 a.m.</p> <p>R2's Treatments Administration History dated September 1, 2021, through September 15, 2021, included:<br/>-Order: Blood Sugar Check;<br/>-Frequency: Once a Day; and</p> | 01950                                                                                        |                                                                                                                          |                                                        |

Minnesota Department of Health

|                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |                                                                                              |                                                                                                                          |                                                        |
|--------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                      |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br><b>20568</b>                    | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: _____<br><br>B. WING: _____                                                   | (X3) DATE SURVEY<br>COMPLETED<br><br><b>09/17/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>LAKESIDE GENERATIONS ASSISTED</b> |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>441 WILLIAM AVENUE EAST<br/>DASSEL, MN 55325</b> |                                                                                                                          |                                                        |
| (X4) ID<br>PREFIX<br>TAG                                                 | SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | ID<br>PREFIX<br>TAG                                                                          | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) | (X5)<br>COMPLETE<br>DATE                               |
| 01950                                                                    | <p>Continued From page 29</p> <p>-Special Instructions- was left blank.</p> <p>On September 16, 2021, at approximately 8:30 a.m., RN-B confirmed R2's record did not contain specific instructions for blood glucose monitoring and when to notified the nurse.</p> <p>The licensee's Delegation of Nursing Tasks policy dated August 1, 2021, verified prior to delegation of administration of treatments the RN or authorized Licensed Health Professional would develop written specific instructions for each "client" would be in the "client's record."</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p> | 01950                                                                                        |                                                                                                                          |                                                        |

Type: Full  
Date: 09/15/21  
Time: 10:51:24  
Report: 7978211141

## Food and Beverage Establishment Inspection Report

Page 1

**Location:**

Lakeside Generations  
439 William Avenue East  
Dassel, MN55325  
Meeker County, 47

**Establishment Info:**

ID #: N054865  
Risk:  
Announced Inspection: No

**License Categories:**

Expires on: / /

**Operator:**

Phone #:  
ID #:

The violations listed in this report include any previously issued orders and deficiencies identified during this inspection. Compliance dates are shown for each item.

The following orders were issued during this inspection.

### 4-700 Sanitizing Equipment and Utensils

4-702.11 \*\* Priority 1 \*\*

MN Rule 4626.0900 Sanitize utensils and food contact surfaces of equipment before use, after cleaning. ALL DISHES MUST BE SANITIZED IN MAIN KITCHEN. SIGN IN SERVING KITCHEN INDICATED THAT PITCHERS SHOULD BE WASHED IN SERVING KITCHEN. REMOVE SIGN AND ENSURE ALL DISHES ARE WASHED, RINSED, AND SANITIZED IN THE MAIN KITCHEN.

Comply By: 09/15/21

### 4-200 Equipment Design and Construction

4-202.11 \*\* Priority 2 \*\*

MN Rule 4626.0515 Discontinue use of multi-use food-contact surfaces that are not smooth, free of breaks, open seams, cracks, chips, pits and other imperfections and that are not accessible for cleaning or inspection. IF CURRENT OPERATION IS TO CONTINUE WHERE FOOD PREP IS BEING CONDUCTED IN SERVING KITCHEN, COUNTERTOPS MUST BE REPLACED WITH AND APPROVED SURFACE.

Comply By: 09/15/22

### 5-200C Plumbing: Maintenance, fixture location

5-205.11AB \*\* Priority 2 \*\*

MN Rule 4626.1110AB The handwashing sink must be accessible at all times for employee use, and must be used only for handwashing.

DISCONTINUE USING HANDWASHING SINK IN SERVING KITCHEN AS A DUMP SINK.

Comply By: 09/15/21

Type: Full  
Date: 09/15/21  
Time: 10:51:24  
Report: 7978211141  
Lakeside Generations

# Food and Beverage Establishment Inspection Report

Page 2

---

## 4-200 Equipment Design and Construction

4-201.11AMN

MN Rule 4626.0506A Provide or replace food service equipment with equipment that is certified or classified for sanitation by an American National Standards Institute (ANSI) accredited certification program.

"GRIDDLE," DOMESTIC STOVE/OVEN, AND UPRIGHT REFRIGERATORS ARE NOT ANSI APPROVED. REPLACE WITH ANSI APPROVED PIECES OF EQUIPMENT IF FOOD PREP IS TO CONTINUE IN SERVING KITCHEN AREA.

*Comply By: 09/15/22*

## 6-100 Physical Facility Construction Materials

6-101.11A1

MN Rule 4626.1325A1 Provide smooth, durable, and easily cleanable floor, wall and ceiling surfaces. REMOVE CARPET UNDER SELF-SERVE COFFEE/JUICE TABLE. PROVIDE A SMOOTH AND EASILY CLEANABLE FLOOR SURFACE IN THIS AREA.

*Comply By: 09/15/22*

---

## Surface and Equipment Sanitizers

Quaternary Ammonia: = 400 at Degrees Fahrenheit  
Location: SPRAY BOTTLE  
Violation Issued: No

---

## Food and Equipment Temperatures

Process/Item: Steam Table  
Temperature: 168 Degrees Fahrenheit - Location: COOKED NOODLES  
Violation Issued: No

---

Process/Item: Steam Table  
Temperature: 184 Degrees Fahrenheit - Location: ALFREDO SAUCE  
Violation Issued: No

---

Process/Item: Steam Table  
Temperature: 155 Degrees Fahrenheit - Location: COOKED BROCCOLI  
Violation Issued: No

---

Process/Item: Steam Table  
Temperature: 190 Degrees Fahrenheit - Location: BAKED BEANS  
Violation Issued: No

---

Process/Item: Steam Table  
Temperature: 180 Degrees Fahrenheit - Location: HAMBURGER PATTY  
Violation Issued: No

---

Process/Item: Upright Cooler  
Temperature: 39 Degrees Fahrenheit - Location: SLICED CHEESE  
Violation Issued: No

---

Type: Full  
Date: 09/15/21  
Time: 10:51:24  
Report: 7978211141  
Lakeside Generations

# Food and Beverage Establishment Inspection Report

Page 3

Process/Item: Upright Cooler  
Temperature: 38 Degrees Fahrenheit - Location: MILK  
Violation Issued: No

---

---

| Total Orders | In This Report | Priority 1 | Priority 2 | Priority 3 |
|--------------|----------------|------------|------------|------------|
|              |                | 1          | 2          | 2          |

9/15/21 -

KITCHEN INSPECTION PERFORMED IN CONJUNCTION WITH HEALTH REGULATION DIVISION'S INSPECTION OF ASSISTED LIVING FACILITY.

ESTABLISHMENT HAS A "SERVING KITCHEN" FOR THE ASSISTED LIVING FACILITY. MOST OF THE FOOD THAT IS SERVED IS PREPARED OUT OF THE MAIN KITCHEN IN THE NURSING HOME. ITEMS SUCH AS EGGS, GRILLED CHEESE SANDWICHES, AND PATTY MELTS ARE PREPARED IN SERVING KITCHEN VIA THE USE OF A DOMESTIC GRIDDLE. SERVING KITCHEN HAS DOMESTIC PRESSED WOOD CABINETS, A DOMESTIC STOVE/OVEN, A GRIDDLE, A STEAM TABLE, A DROP-IN 2 COMPARTMENT SINK, AND 2 DOMESTIC REFRIGERATOR/FREEZER UNITS. OUTSIDE OF THE SERVING KITCHEN, THERE IS A SELF-SERVICE BEVERAGE STATION THAT HOUSES A COFFEE MACHINE AND A JUICE MACHINE.

RESIDENTS SEAT THEMSELVES IN THE DINING AREA AND DIETARY AIDES PLATE THE MEALS IN THE SERVING KITCHEN. ONCE THE MEALS ARE PLATED, NURSING ASSISTANTS FROM THE ASSISTED LIVING BRING THE PLATES TO THE SEATED RESIDENTS.

ONCE RESIDENTS ARE FINISHED, THE NURSING ASSISTANTS CLEAR THE TABLES. DISHES AND UTENSILS ARE RETURNED TO THE MAIN KITCHEN TO BE WASHED, RINSED, AND SANITIZED.

**NOTE: Plans and specifications must be submitted for review and approval prior to new construction, remodeling or alterations.**

I acknowledge receipt of the Minnesota Department of Health inspection report number 7978211141 of 09/15/21.

Certified Food Protection Manager: \_\_\_\_\_

Certification Number: \_\_\_\_\_ Expires: \_\_\_\_/\_\_\_\_/\_\_\_\_

Signed: \_\_\_\_\_  
Establishment Representative

Signed: \_\_\_\_\_  
Inspector ID #7978

651-201-4500  
health.foodlodging@state.mn.us