DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 23, 2023

Administrator
Lakeshore Rehabilitation Center, LLC
108 8th Street Northwest
Waseca, MN 56093

RE: CCN: 245388
Cycle Start Date: June 7, 2023

Dear Administrator:

On August 17, 2023, we notified you a remedy was imposed. On August 17, 2023 the Minnesota Department(s) of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of August 1, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 7, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of August 17, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 7, 2023, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 1, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies. Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 10, 2023

Administrator
Lakeshore Rehabilitation Center, LLC
108 - 8th Street Northwest
Waseca, MN 56093

RE: CCN: 245388
Cycle Start Date: June 7, 2023

Dear Administrator:

On June 7, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

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

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

If substantial compliance with the regulations is not verified by September 7, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 7, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245388	A. BUILDING _____ B. WING _____	C 06/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE REHABILITATION CENTER LLC	108 8TH STREET NORTHWEST WASECA, MN 56093

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 6/5/23 to 6/7/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 039 SS=F	EP Testing Requirements CFR(s): 483.73(d)(2) §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is	E 039		8/1/23

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

Electronically Signed | 07/18/2023

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

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E 039	Continued From page 1 community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or	E 039		

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E 039	Continued From page 2 (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from	E 039		

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E 039	Continued From page 3 engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the	E 039		

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E 039	Continued From page 4 onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2	E 039		

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E 039	Continued From page 5 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year, including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that	E 039		

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E 039	Continued From page 6 may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or	E 039		

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E 039	Continued From page 7 (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is	E 039		

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E 039	Continued From page 8 led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group	E 039		

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E 039	Continued From page 9 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure two emergency preparedness (EP) exercises, including two full-scale community based exercises, or one community based exercise and a table top exercise, or had activated their plan as a result of a actual event, were completed annually to test their EP program. This had the potential to affect all 40 residents residing at the facility. Findings include: During an interview on 6/7/23 at 11:05 a.m., associate administrator (AA)-C stated EP responsibilities were shared between her and the maintenance director (MD)-A, and that no EP drills had been conducted in 2022, neither a full-scale exercise, table-top or actual event. AA-C who had started her role at the facility in July 2022 stated the former administrator had informed her EP exercises had not been conducted due to Covid-19 restrictions. Facility policy titled Emergency Disaster Plans, undated, indicated practice drills would be conducted as follows: --Tornado drills - annually in conjunction with the statewide drill and two to three times during	E 039	Plan of Correction E0039 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: ¿Facility has a table top emergency exercise planned for 7/25/2023. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Facility has completed the emergency exercise and completed an after action report. In order to ensure compliance, Maintenace director and administrator will meet monthly to ensure compliance is sustained and monthly drills have been compleated.	

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E 039	Continued From page 10 tornado season. --Disaster evacuation - yearly. --Community disaster drill or table talk - yearly.	E 039	Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Administrator will review the after action report at next facility□s qapi. Completion date: 8/1/2023	
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.	E 041		7/18/23

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E 041	Continued From page 11 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a	E 041		

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E 041	Continued From page 12 document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition) 8.4.9, 8.4.9.2 This deficient condition could have a widespread impact on the residents within the facility. Findings include:	E 041	Plan of Correction—E0041 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice:	

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E 041	Continued From page 13 1. On 06/06/2023 between 9:00 a.m. and 1:00 p.m., it was revealed during documentation review that there was no documentation presented to confirm that once every 36 months - 4 hour continuous run of the emergency generator is occurring. 2. On 06/06/2023 between 9:00 a.m. and 1:00 p.m., it was revealed during documentation review that of monthly generator inspection and testing dated MAY 23, 2023, there was no entries recorded of observed measurements and outputs of the generator. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	E 041	¿Facility has completed the 4 hour load bank test. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Facility has educated maintenance director on frequency of testing . Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Maintenance director will report on any upcoming or overdue tests during quarterly QAPI.	
F 000	INITIAL COMMENTS On 6/5/23 to 6/7/23 a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiency issued: H5388020C (MN80956) H53882616C (MN83424) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are	F 000		

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F 000	Continued From page 14 enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess the resident and determine safety for self-administration of medications (SAM) for 1 of 1 resident (R14) who was observed to have medications at bedside. Findings include: R14's quarterly Minimum Data Set (MDS) assessment dated 4/5/23, indicated intact cognition, required one-person physical assist with bed mobility, transfers, dressing, toilet use, and personal hygiene, and indicated diagnoses including gastro-esophageal reflux disease (digestive disease), osteoarthritis, chronic kidney disease, coronary artery disease, heart failure, and hypertension (high blood pressure). R14's care plan dated 1/18/23, indicated risk for discomfort and interventions included: monitor for	F 554	Plan of Correction—F554 Resident Self-Admin Meds Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: ¿R14 was assessed by the facility for self administration of medications. The facility has determined that R14 is not able to self administer medications. All medications have been removed from resident bedside. How will the facility identify other residents having the potential to be affected by the same deficient practice?	8/1/23

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F 554	Continued From page 15 verbal and nonverbal indicators of discomfort, provide non medicinal forms of pain relief such as positioning, rest, massage, encourage resident to verbalize discomfort, document on pain, keep medical doctor informed. During an observation and interview on 6/5/23 at 1:45 p.m., R14 was seated in recliner and observed multiple containers of over-the-counter meds next to her recliner. On the bottom shelf of the bedside table was a bottle of Equate brand antacid (relieves indigestion and heartburn) tabs, bottle of MiraLAX (constipation medication) powder, Dulcolax (laxative) chewy bites; on the top of the bedside table were two tubes of Aspercreme (provides pain relief), one tube of Cortisone cream, and in the pocket of the recliner were two tubes of Aspercreme, one tube of Cortisone cream (for various skin conditions). R14 stated her family brought the medications and used the cortisone cream for itching, Aspercreme for knees and feet, MiraLAX and Dulcolax for help with constipation, and the antacid for sour stomach. On 6/5/23 at 7:00 p.m., licensed practice nurse (LPN)-A reviewed R14's record and stated R14 did not have a self-administration medication (SAM) assessment and confirmed since R14 did not have a completed SAM the medications should not have been left in R14's room because it was unknown if it was safe for R2 to self-administer. LPN-A further indicated R14's family was known to bring medications in the facility for R14. On 6/5/23 at 7:10 p.m., medications were still located in R14's room. LPN-A confirmed the medications located in R14's room were not	F 554	All residents have the potential to be affected by the alleged deficient practice A complete building audit as been done on all residents to ensure compliance The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Facility in-serviced staff on reporting medications at bedside to the charge nurse or DON. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: DON or Designee will conduct audits 5 times per week for 2 weeks as needed to monitor för compliance.	

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F 554	Continued From page 16 administered or documented by facility staff. R14 stated the medications were used when she needed them for bowels and cream for her knees. LPN-A stated the medications were not expected in R14's room and removed the medications from the room. On 6/5/23 at 7:10 p.m., trained medication aide (TMA)-A stated she was aware of the creams in R14's room and notified a nurse about the medications. TMA-A stated she was not able to recall when or the name of the nurse notified. On 6/6/23 at 1:22 p.m., director of nursing (DON) stated R14 was not assessed for SAM and expectation was for medications not in R14's room. The DON stated the family was known to bring medications for R14 and place at the bedside. The DON stated family member-(FM)-A was educated today family was not to bring medications into R14's room. The DON stated staff were expected to removed medications from R14's room when observed. The facility policy and procedure titled Self administration of medications dated 12/16, indicated Policy: residents have their right to self-administer medications if the interdisciplinary team has determined clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation: 9. Staff shall identify and give to the charge nurse any medications found at the bedside that are not authorized for self-administration for return to the family are responsible party.	F 554		

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F 554	Continued From page 17 11. The nursing staff will routinely check self-administered medications and will remove expired, discontinued, or recalled medications.	F 554		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete a level II preadmission screening and resident review (PASARR) for 2 of 2 residents (R3, R5), reviewed with new mental illness diagnoses. Findings include: R3's face sheet, printed on 6/6/23, indicated R3's original admission date was 5/10/19, diagnosis at time included anxiety disorder. Further review of	F 644	Plan of Correction—F644 PAASAR Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: ¿R3 and R5 have been re-evaluated and	8/1/23

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F 644	Continued From page 18 the diagnosis listed on face sheet, indicated R3 was diagnosed with a mood disorder on 6/16/21 and psychosis (a mental disorder causing disconnection from reality), not due to a substance or known physiological condition, on 3/17/22. R3's quarterly Minimum Data Set (MDS) assessment dated 5/19/23, indicated R3 had intact cognition and received antidepressant medication. R3's current physician orders, printed 6/6/23, included: monitoring for adverse side effects due to psychotropic medication use (medications altering mood/mental state), quetiapine fumarate (Seroquel, an antipsychotic (mood/mental state altering) medication); 125 mg twice daily related to psychosis not due to a substance or known physiological condition, and monitoring orthostatic blood pressures once monthly due to psychotropic medication use. R3's care plan, last reviewed on 6/1/23, included: R3 had behaviors related to (R/T) psychosis, mood disorder, and anxiety; may yell out for help, shout, scream, and swear at staff, hit, and attempt to bite staff. Interventions included social services to assist resident and family as needed (PRN). Furthermore, upon record review, R3 had not been evaluated for or had received mental health services with new mental illness diagnoses updated on 6/16/21 and 3/17/22. Record review of R3's PASARR screen, completed on 5/10/19, indicated negative level 1 screening, level 2 screening not needed at time. Record review indicated R3 had resided at facility	F 644	have current Level 2 screenings. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice All facility residents have been audited to ensure compliance The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Facility educated social services director on obtaining a level two screen after a significant change involving a new mental health diagnosis. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: SSD or Designee will conduct audits 5 times per week for 2 weeks as needed to monitor för compliance.	

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F 644	Continued From page 19 since admission on 5/10/19, was sent to hospital for an acute medical condition and readmitted back to facility on 5/3/22, no PASARR screen completed prior to facility readmission. R5's face sheet, provided by via email to surveyor on 6/8/23, indicated R5's original admission date was 1/12/10, diagnosis at time included major depressive (mood altering) disorder. Further review of the diagnosis listed on face sheet, indicated R5 was diagnosed with delusional (false judgements/beliefs regarding reality) disorder on 5/5/16 and unspecified dementia (brain dysfunction) with behavioral disturbances on 10/1/22. R5's quarterly Minimum Data Set (MDS) assessment dated 5/5/23, indicated R3 had moderately impaired cognition and received antipsychotic, antidepressant, and opioid medications. R5's current physician orders, provided via email to surveyor on 6/8/23, included: documentation of behaviors every shift to capture mood and behaviors for antipsychotic utilization, administer aripiprazole (antipsychotic) 4 mg daily in morning R/T delusional disorders, administer sertraline 200 mg daily in the morning R/T major depressive disorder, monitoring of orthostatic blood pressure once monthly while receiving psychotropic medications, and monitoring for adverse side effects due to psychotropic medication use. R5's care plan, last reviewed on 6/1/23, included: R5 had alteration in mood and behaviors, and potential for alteration in psychosocial well-being R/T dementia with behavioral disturbance, major depressive disorder, and delusional disorder.	F 644		

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F 644	Continued From page 20 Interventions included monitoring and documentation of mood and behaviors occurred, social services to assist resident and family PRN, and monitoring mood state, refer PRN. Furthermore, upon record review, R5 had not been evaluated for or had received mental health services with new mental illness diagnoses updated on 5/5/16 and 10/1/22. Record review of R5's PASARR screen, completed on 5/4/16, indicated negative level 1 screening, level 2 screening not needed at time. Record review indicated R5 had resided at facility since admission on 1/12/10, was sent to hospital for an acute medical condition and readmitted back to facility on 8/27/18, no PASARR screen completed prior to facility readmission. During an interview, on 6/6/23 at 12:39 p.m., with registered nurse (RN)-A and director of nursing (DON), indicated PASARR screens were completed prior to facility admission, at time of a resident's significant change in status, or new mental health diagnosis was noted. RN-A stated all residents, when had a significant change in status or new diagnoses were reported, was discussed at interdisciplinary team (IDT) meetings once weekly. DON indicated social services (SS) present at weekly IDT meetings, SS manages PASARR screening evaluations and referrals for further follow-up. When interviewed, on 6/6/23 at 12:47 p.m., SS-A indicated she received resident PASARR level 1 screening evaluations prior to hospital discharge and facility admission, if resident needing PASARR 2 level screening prior to facility admission, hospital is responsible for referral of	F 644		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE REHABILITATION CENTER LLC	108 8TH STREET NORTHWEST WASECA, MN 56093

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 644	Continued From page 21 further follow-up for mental health service needs. SS-A stated if residents already admitted to facility had new mental health changes or new mental health diagnoses, SS-A was notified of these new changes at clinical meeting, held daily in the morning, with IDT. SS-A indicated new mental health changes or new mental health diagnoses were also discussed weekly with IDT at target behavior meetings, meetings held to discuss residents' psychotropic medications and behaviors. SS-A reviewed R3 and R5's most recent PASARR screens completed, SS-A indicated R3's most recent PASARR screen was completed 5/10/19, R3 had new diagnoses of mood disorder on 6/16/21 and psychosis, not due to a substance or known physiological condition, on 3/17/22 and R3 had not been referred for level II PASARR since diagnosed with new mental illness conditions. SS-A stated unawareness of R3's new mental health diagnosis and need for referral for mental health services, indicated awareness PASARR only needed to be completed prior to facility admission, SS-A confirmed she should have referred R3 to mental health services for further evaluation and follow-up of new mental illness diagnoses. SS-A indicated R5's most recent PASARR screen was completed 5/4/16, R5 had new diagnoses of delusional disorder identified on 5/5/16 and unspecified dementia with behavioral disturbances identified on 10/1/22; R5 had not been referred for level II PASARR since diagnosed with new mental illness conditions, SS-A confirmed R5 also should have been referred to mental health services for further evaluation and follow-up of new mental illness diagnoses. Facility policy titled Pre-Admission Screening	F 644		

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F 644	Continued From page 22 (PAS), revised date 4/23, indicated to ensure that residents admitted to the health care center meet specified criteria for appropriateness of placement. Procedure consisted of; Social Services will check for preadmission screening and OBRA Level II requirements, Pre-Admission Screening assistance can be found at: Preadmission Screening/Minnesota Board on Aging (MBA) (mn.gov).	F 644		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to mark/date opened containers of food stored in one kitchen refrigerators, a refrigerated sandwich prep table, and one freezer; and failed to ensure	F 812	Plan of Correction—F812 Food Storage Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability	8/1/23

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F 812	Continued From page 23 expired/damaged food were identified and removed. This had the potential to affect all 40 residents who were served food and beverages from the facility kitchen. Findings include: During interview and observation of kitchen on 6/6/23, at 11:50 a.m. with culinary director (CD)-D, observed food items in the refrigerated sandwich prep table, walk-in refrigerator, beverage service station refrigerator, and beverage service station freezer, that were not dated or marked and/or were expired/damaged. CD-D indicated all kitchen staff were responsible for checking food for opened dates and expiration dates, removing all expired/damaged foods when noted or per facility policy. CD-D indicated if any food or drink is not dated when opened, it should be removed immediately. CD-D indicated all left-over prepared food and beverages when dated/marked were good for 7 days from date opened per facility policy. The following items were observed during tour: Refrigerated sandwich prep table: 1. Kemps 2% Low-fat cottage cheese- approximately½ full; not marked/dated when opened; expiration date 5/24/23. 2. Strawberry strudels enclosed in facility container- ½ full; not marked/dated when opened; use by date of 5/27/23 Walk-in refrigerator: 1.Premade scrambled eggs in sealed plastic bag- full; not marked/dated when opened; no expiration on bag 2.California Berry Farms fresh strawberries (2 small plastic cartridges)- approximately ½ full,	F 812	by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: ¿Facility has removed all items in the kitchen that were noted to be expired. All dietary staff was educated on dating and labeling food items and discarding them appropriately. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Education of labeling and dating with all dietary staff. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Dietary manager or designee will conduct audits 5 days per week for 2 weeks to insure compliance.	

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F 812	Continued From page 24 unmarked/undated, no expiration date. Strawberries observed to have mold covering bottom half of strawberries, areas of strawberries appeared white with dark discoloration, had areas of fuzzy growth, foul odor present Beverage service station freezer: 1.One scoop plain white ice cream in facility Styrofoam cup (2)- uncovered, not marked/dated, no expiration/use by date. Ice cream slightly melted, refrozen During an interview on 6/6/23 at 1:03 p.m., CD-D indicated in discussion of unmarked/undated and expired/damaged food items; all staff were responsible to go through all refrigerators and freezers to check food items and remove all food items noted to be unmarked/undated and/or expired/damaged daily. CD-D stated having difficulty getting dietary staff to perform these routine food item checks when directed. CD-D indicated he has taken over performing routine food item checks, admitted was so busy with other dietary assignments, routine food item checks not completed daily as should have been. CD-D stated he had discussed concerns of dietary staff not performing dietary task assignments as directed to per CD-D's delegation with associate administrator (AA)-A, AA-A plans to further address with dietary staff. When interviewed on 6/7/23 at 11:40 a.m., AA-A indicated awareness of CD-D's concerns with dietary staff not performing dietary assignments, CD-D has had to perform most dietary task assignments by self. AA-A stated many staff are working through new adjustments of rules and expectations set per management team since new ownership of facility. AA-A stated this was a	F 812		

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F 812	Continued From page 25 new concern was just recently brought to her attention per CD-D, management team currently working on plan for dietary job duties, including behavioral rules/expectations for culinary staff. Facility policy for food storage was requested on 6/6/23, received facility policy for food storage of non-perishable food items only. Facility policy titled Food Storage-Non-Perishable, revised date 9/12, consisted of; it is the policy of Monarch Healthcare Management to maintain sanitary techniques in non-perishable food storage in order to protect the health of those dependent on the service, the remaining contents of opened food packages will be stored in plastic containers with tight-fitting lids or plastic zip lock bags and all containers will be properly labeled and dated as to contents.	F 812		

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	245388	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2023**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/06/2023. At the time of this survey, LAKESHORE REHABILITATION CENTER was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/20/2023

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. LAKESHORE REHABILITATION CENTER is a 1 story building with partial basement. The building was constructed at 4 different times. The original building was constructed in 1960 and was determined to be of Type II(111) construction. In 1968, addition was constructed to the South Wing that was determined to be of Type II(111) construction. In 1984, another addition was added to the South Wing and was determined to	K 000		

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K 000	Continued From page 2 be Type II (111). In 1998, an addition was added to the East Wing and was determined to be Type II (111) construction. Because the original building and the 3 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and properly maintain	K 271	Plan of Correction—K271 Please accept the following as the	8/1/23

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K 271	Continued From page 3 points of exit in accordance with the NFPA 101 (2012 edition), Life Safety Code, sections 19.2.7, 7.1.6.2. This deficient condition could have a patterned impact on the residents within the facility. Findings include: On 06/06/2023 between 9:00AM and 1:00 PM, it was revealed by observation that to the exterior of the West Exit Door, the concrete slab had a vertical displacement greater that 1 inch presenting a fall and trip hazard in the path of egress An interview with the Facility Director verified this deficient finding at the time of discovery.	K 271	facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: ¿Facility has installed a piece of corrugated aluminum resolving the vertical displacement on 8/1/2023 How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Facility will complete monthly audits of all exits to insure they are maintained properly. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Maintenance director will report on any unresolved issues to QAPI on a quarterly basis. Completion date: 08/01/2023	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING	K 374		8/1/23

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K 374	Continued From page 4 Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 06/06/2023 between 9:00AM and 1:00 PM, it was revealed by observation that the smoke barrier doors in the area of the Dining Room and South Wing, upon testing, did not self-close and seal the opening. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	Plan of Correction—K374 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: ¿The identified door closer was repaired. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Facility maintenance will inspect all fire doors on a monthly basis. Quality Assurance plans to monitor facility performance to make sure that	

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K 374	Continued From page 5	K 374	corrections are achieved and are permanent: Maintenance director will report on any unresolved issues to QAPI on a quarterly basis. Completion date: 8/1/2023	
K 914 SS=C	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct electrical receptacle testing in resident rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2.1 to 6.3.3.2.4, 6.3.4.1.3,	K 914	Plan of Correction—K914 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability	8/1/23

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K 914	Continued From page 6 6.3.4.2.1.1, 6.3.4.2.1.2 This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 06/06/2023 between 9:00AM and 1:00 PM, it was revealed by a review of available documentation that there was no identifier as to who completed the inspection and testing, sheets were found undated as to when that work was completed, and testing results for each individual outlet was not documented. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 914	by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice: ¿Facility completed testing of all electrical outlets 8/1/2023 How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Facility educated maintenance director on documenting date and signature completed on each sheet. Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Maintenance director will report on any unresolved issues to QAPI on a quarterly basis. Completion date: 08/01/2023	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this	K 918		8/1/23

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LAKESHORE REHABILITATION CENTER LLC	**108 8TH STREET NORTHWEST** **WASECA, MN 56093**

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K 918	Continued From page 7 capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, 6.4.4.2 and NFPA 110 (2010 edition) 8.4.9, 8.4.9.2 This deficient condition could have a widespread impact on the residents within the facility. Findings include:	K 918	Plan of Correction—K918 Please accept the following as the facility's credible allegation of compliance. This Plan of Correction does not constitute any admission of guilt or liability by the facility and is submitted only in response to the regulatory requirements. How corrective action will be taken for those affected by the alleged deficient practice:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245388	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/06/2023**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 918	Continued From page 8 1. On 06/06/2023 between 9:00AM and 1:00 PM, it was revealed during documentation review that there was no documentation presented to confirm that once every 36 months - 4 hour continuous run of the emergency generator is occurring. 2. On 06/06/2023 between 9:00AM and 1:00 PM, it was revealed during documentation review that of monthly generator inspection and testing dated MAY 23, 2023, there was no entries recorded of observed measurements and outputs of the generator. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 918	¿Facility has completed the 4 hour load bank test. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the alleged deficient practice The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not occur: Facility has educated maintenance director on frequency of testing . Quality Assurance plans to monitor facility performance to make sure that corrections are achieved and are permanent: Maintenance director will report on any upcoming or overdue tests during quarterly QAPI. Completion date: 08/01/2023	