

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered May 5, 2017

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

Subject: Lakeshore Inn Nursing Home - Independent Dispute Resolution (IDR) CMS Certification Number: 24 5388 Project Number: S5388027

Dear Mr. Corchran:

This is in response to your letter of August 15, 2016, in regard to your request of an informal dispute resolution (IDR) for the Federal deficiency at tag F309 Quality of Care issued pursuant to the survey event BU2K11, completed on July 21, 2016.

The information presented with your letter, the CMS 2567 dated July 21, 2016 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

F309 Quality of Care, scope and severity G, 42 CFR § 483.25: Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Summary of facts:

The facility disputes the scope and severity G, isolated actual harm, for F309, Quality of Care. The facility alleges the resident did not sustain harm by not receiving additional pain medications.

The resident was admitted to the facility on November 13, 2013. The resident had a history of CVA with right sided hemiplegia since 2002, dysphagia, and pneumonia. The resident had a hospital stay from October 9, 2015 to October 14, 2015, for pneumonia and was admitted back to the facility October 14, 2015.

Interviews with three nursing assistants indicated the resident displayed pain to his/her right arm/hand. Two nurses indicated if a resident had a change in pain, nursing assistants should report the pain to the nurse on duty.

A statement from a family member during an observation on July 20, 2016 at 2:29 p.m., indicated the resident's right arm/hand was hurting him/her.

Lakeshore Inn Nursing Home May 5, 2017 Page 2

A statement from the OTRL during an observation July 20, 2016 at 12:47 p.m., indicated the resident's right side was very sensitive.

Summary of findings:

The resident was admitted to the facility November 13, 2013. The resident had a history of CVA with right sided hemiplegia since 2002 and dysphagia.

The facility's daily pain assessments and physician visit summaries dated from October 15, 2015 to July 19, 2016, indicated the resident denied pain with the exception of a catheter removal on October 15, 2015. However, nursing progress notes indicated the resident had expressed pain twice during the month of May 2016 for "all over" pain, including abdominal and leg pain; in addition, the resident had complained of pain six times during the month of June 2016, for pain that was "all over" which was treated with medication as prescribed by the physician and was effective.

The surveyor observed the resident on July 19, 2016 at 6:00 p.m. The resident was observed to display non-verbal and verbal cues related to pain anytime the right arm/hand was touched.

The surveyor also observed the resident to display non-verbal and verbal signs of pain to the right arm/hand on July 20, 2016 at 11:00 a.m., 12:47 p.m., 2:29 p.m. and 7:15 p.m., and again on July 21, 2016 at 10:09 a.m.

This is a valid deficiency at this tag, and at the correct scope and severity of G.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

. Wush

Annette Winters, Unit Supervisor Office of Health Facility Complaints Health Regulation Division Telephone: 651-201-4204 Fax: 651-281-9796

cc: Office of Ombudsman for Long-Term Care Maria King, Assistant Program Manager Kathy Serie, Mankato District Office Unit Supervisor Licensing and Certification File

| DEPARTMENT OF HEALT | H AND HUMA | N SERVICES | | | CENTERS FOR MEI | DICARE & MEDICAID SERVICES | | |
|--|---|--|----------------------------|---------------------|--|---|--|--|
| | MEDICA | ARE/MEDICAL | D CERTIFIC | CATION A | AND TRANSMITTAL | ID: BU2K | | |
| | PART I - | TO BE COMPI | LETED BY 1 | THE STAT | FE SURVEY AGENCY | Facility ID: 00682 | | |
| 1. MEDICARE/MEDICAID PROVID NO.(L1) 245388 | DER | 3. NAME AND AI (L3) LAKESHOI | | | ſE | 4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification | | |
| 2. STATE VENDOR OR MEDICAID (L2) 593043000 | D NO. | (L4) 108 8TH ST (L5) WASECA, N | | HWEST | (L6) 56093 | 3. Termination 4. CHOW 5. Validation 6. Complaint | | |
| 5. EFFECTIVE DATE CHANGE OF | OWNERSHIP | 7. PROVIDER/SU | JPPLIER CATEC | ORY | <u>02</u> (L7) | 7. On-Site Visit 9. Other | | |
| (L9) | (24) | 01 Hospital 05 HHA 09 ESRD | | | 13 PTIP 22 CLIA | 8. Full Survey After Complaint | | |
| 6. DATE OF SURVEY 9/6/ 8. ACCREDITATION STATUS: | /2016 (L34) (L10) | 02 SNF/NF/Dual 03 SNF/NF/Distinct | 06 PRTF 07 X-Ray | 10 NF 11 ICF/III | 14 CORF 0 15 ASC | FISCAL YEAR ENDING DATE: (L35) | | |
| 0 Unaccredited1 TJC2 AOA3 Other | (L10) | 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | 12/31 | | |
| 11LTC PERIOD OF CERTIFICATIO | N | 10.THE FACILITY | IS CERTIFIED | AS: | | | | |
| From (a): | | X A. In Complia | ance With | | And/Or Approved Waivers Of | The Following Requirements: | | |
| To (b): | | Program Re | equirements e Based On: | | 2. Technical Personnel 3. 24 Hour RN | 6. Scope of Services Limit 7. Medical Director | | |
| 10 T-t-l E-cilite D-d- | 77 (119) | 1. A | cceptable POC | | 4. 7-Day RN (Rural SN | NF) 8. Patient Room Size | | |
| 12.Total Facility Beds 13.Total Certified Beds | 55 (L18)55 (L17) | B. Not in Comp | 1 | | 5. Life Safety Code | 9. Beds/Room | | |
| 15. Total Certified Beds | 55 (LI7) | | and/or Applied V | | * Code: | (L12) | | |
| 14. LTC CERTIFIED BED BREAKDO | OWN | I | | | 15. FACILITY MEETS | | | |
| 18 SNF 18/19 SNF | 19 SNF | ICF | IID | | 1861 (e) (1) or 1861 (j) (1): | (L15) | | |
| 55 | | | | | | | | |
| (L37) (L38) | (L39) | (L42) | (L43) | | | | | |
| 16. STATE SURVEY AGENCY REM | IARKS (IF APPLICA | BLE SHOW LTC CA | ANCELLATION | DATE): | | | | |
| | | | | | | | | |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SURVEY AGENCY | APPROVAL Date: | | |
| Susan Kalis, HFE NE II | | 9 | 0/13/2016 | (L19) | K <u>amala Fiske-Downing, Hea</u> | alth Program Representative 09/13/2016 (L20) | | |
| PA | RT II - TO BE | COMPLETED I | BY HCFA RI | EGIONAI | L OFFICE OR SINGLE S | STATE AGENCY | | |
| 19. DETERMINATION OF ELIGIBII | LITY | | IPLIANCE WITH | H CIVIL | Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : | | | |
| 1. Facility is Eligible to I | Participate | RIGH | HTS ACT: | | | | | |
| 2. Facility is not Eligible | | | | | | | | |
| | (L21) | | | | | | | |
| 22. ORIGINAL DATE | 23. LTC AGREEN | MENT 24 | 4. LTC AGREEN | MENT | 26. TERMINATION ACTION | : (L30) | | |
| OF PARTICIPATION | BEGINNING | DATE | ENDING DA | TE | VOLUNTARY 0 |) INVOLUNTARY | | |
| 12/01/1986 | | | | | 01-Merger, Closure | 05-Fail to Meet Health/Safety | | |
| (L24) | (L41) | | (L25) | | 02-Dissatisfaction W/ Reimburs | ement 06-Fail to Meet Agreement | | |
| 25. LTC EXTENSION DATE: | 27. ALTERNATI | VE SANCTIONS | | | 03-Risk of Involuntary Terminatio | on <u>OTHER</u> | | |
| | A. Suspension | n of Admissions: | | | 04-Other Reason for Withdrawal | 07-Provider Status Change | | |
| (L27) | D D | Deter | (L44) | | | 00-Active | | |
| | B. Rescind St | spension Date: | (1.45) | | | | | |
| | | | (L45) | | | | | |
| 28. TERMINATION DATE: | 29 | . INTERMEDIARY/ | CARRIER NO. | | 30. REMARKS | | | |
| | | 03001 | | | | | | |
| | (L28) | | | (L31) | | | | |
| 31. RO RECEIPT OF CMS-1539 | 32 | . DETERMINATION | I OF APPROVAI | . DATE | | | | |
| | | | | - | | | | |
| | (L32) | | | (L33) | DETERMINATION APP | ROVAL | | |



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245388

September 13, 2016

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

Dear Mr. Corchran:

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

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

Effective September 13, 2016 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Telephone: (651) 201-4112 Fax: (651) 215-9697



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered September 13, 2016

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

RE: Project Number S5388027

Dear Mr. Corchran:

On August 4, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 21, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 13, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 13, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 21, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 21, 2016, effective September 13, 2016 and therefore remedies outlined in our letter to you dated August 4, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Kumalu Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program

Lakeshore Inn Nursing Home September 13, 2016 Page 2

Program Assurance Unit Health Regulation Division 85 East Seventh Place, Suite 220 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

POST-CERTIFICATION REVISIT REPORT

| | MULTIPLE CONSTRUCTION A. Building | | DATE OF F | REVISIT |
|-------------------------|--------------------------------------|---------------------------------------|-----------|---------|
| | B. Wing | Y2 | 9/6/2016 | Y3 |
| NAME OF FACILITY | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAKESHORE INN NURSING H | OME | 108 8TH STREET NORTHWEST | | |
| | | WASECA, MN 56093 | | |

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

| ITEM | DATE | ITEM | | DATE | ITEM | | DATE |
|---------------------------------------|---------------------------|--|----------------------------------|--------------------------|-----------|--------------|------------|
| Y4 | Y5 | Y4 | | Y5 | Y4 | | Y5 |
| ID Prefix F0282 | Correction | ID Prefix | F0309 | Correction | ID Prefix | F0318 | Correction |
| Reg. # 483.20(k)(3)(ii) | Completed | Reg. # 4 | 483.25 | Completed | Reg. # | 483.25(e)(2) | Completed |
| LSC | 08/25/2016 | LSC | | 08/22/2016 | LSC | | 08/25/2016 |
| ID Prefix F0465 | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| 483.70(h) Reg. # | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | 09/05/2016 | LSC | | _ | LSC | | |
| ID Prefix | Correction | ID Prefix _ | | Correction | ID Prefix | | Correction |
| Reg. # | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | LSC | | _ | LSC | | |
| ID Prefix | Correction | ID Prefix _ | | Correction | ID Prefix | | Correction |
| Reg. # | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | LSC | | _ | LSC | | |
| ID Prefix | Correction | ID Prefix _ | | Correction | ID Prefix | | Correction |
| Reg. # | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | LSC | | _ | LSC | | |
| REVIEWED BY STATE AGENCY | REVIEWED BY (INITIALS) | DATE | SIGNATURE OF | SURVEYOR | I | DATE | |
| | /KS/kfd | 9/13/201 | | | 37041 | | 2016 |
| REVIEWED BY CMS RO | REVIEWED BY (INITIALS) | DATE | TITLE | | | DATE | |
| FOLLOWUP TO SURVE 7/21/2016 | CHEC UNCO | CK FOR ANY UNCORRE DRRECTED DEFICIENC | CTED DEFICIEN DIES (CMS-2567) | NCIES. WAS SENT TO TH | | /es 🗌 No | |

POST-CERTIFICATION REVISIT REPORT

| | MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 | | DATE OF | REVIS | IT | |
|----------------------------|---|---------------------------------------|----------|-------|----|--|
| | B. Wing | Y2 | 9/13/201 | 6 | Y3 | |
| NAME OF FACILITY | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | |
| LAKESHORE INN NURSING HOME | | 108 8TH STREET NORTHWEST | | | | |
| | | WASECA, MN 56093 | | | | |

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

| ITEI | | DATE | ITEM | DATE | ITEM | DATE |
|--|----------|-------------------------------------|--------------------------|--|-----------------|--------------------------|
| Y4 | | Y5 | Y4 | Y5 | Y4 | Y5 |
| ID Prefix | | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | NFPA 101 | Completed | Reg. # | Completed | Reg. # NFPA 101 | Completed |
| LSC | K0025 | 08/12/2016 | LSC <u>K0038</u> | 08/22/2016 | LSC K0056 | 09/13/2016 |
| ID Prefix | | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | NFPA 101 | Completed | Reg. # | 101 Completed | Reg. # | Completed |
| LSC | K0062 | 08/12/2016 | LSC K0072 | 08/12/2016 | | |
| ID Prefix | | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | | LSC | | LSC | |
| ID Prefix | | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | | LSC | | LSC | |
| ID Prefix | | Correction | ID Prefix | Correction | ID Prefix | Correction |
| Reg. # | | Completed | Reg. # | Completed | Reg. # | Completed |
| LSC | | | LSC | | LSC | |
| REVIEWE STATE AC | | REVIEWED BY (INITIALS) TL/kfd | DATE 9/13/2016 | SIGNATURE OF SURVEYOR | 37008 | DATE 9/13/2016 |
| REVIEWE CMS RO | | REVIEWED BY (INITIALS) | DATE | TITLE | | DATE |
| FOLLOWUP TO SURVEY COMPLETED ON 7/21/2016 | | | | R ANY UNCORRECTED DEFICIEN CTED DEFICIENCIES (CMS-2567) | | |



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

September 13, 2016

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

Re: Reinspection Results - Project Number S5388027

Dear Mr. Corchran:

On September 13, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 6, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division 85 East Seventh Place, Suite 220 St. Paul, MN 55164-0900 Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

STATE FORM: REVISIT REPORT

| | MULTIPLE CONSTRUCTION A. Building | | | DATE OF REVIS | SIT |
|----------------------------|--------------------------------------|---------------------------------------|----|---------------|-----|
| | B. Wing | Ň | Y2 | 9/6/2016 | Y3 |
| NAME OF FACILITY | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| LAKESHORE INN NURSING HOME | | 108 8TH STREET NORTHWEST | | | |
| | | WASECA, MN 56093 | | | |

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

| ITE | Μ | DATE | ITEM | | DATE | ITEM | | DATE |
|---|-------------------------------|---------------------------|-------------------|------------------------|------------|-----------|-------------------------------|-------------|
| Y4 | | Y5 | Y4 | | Y5 | Y4 | | Y5 |
| ID Prefix | 20565 | Correction | ID Prefix 208 | 30 | Correction | ID Prefix | 20895 | Correction |
| Reg. # | MN Rule 4658.0 Subp. 3 | Completed | Reg. # MN Subp | Rule 4658.0520 p. 1 | Completed | Reg. # | MN Rule 4658.052 Subp. 2.B | 5 Completed |
| LSC | | 08/25/2016 | | | 08/22/2016 | LSC | | 08/25/2016 |
| ID Prefix | 21390 | Correction | ID Prefix 216 | 95 | Correction | ID Prefix | | Correction |
| Reg. # | MN Rule 4658.0 Subp. 4 A-I | Completed | Reg. # MN Subp | Rule 4658.1415 p. 4 | Completed | Reg. # | | Completed |
| LSC | | 08/22/2016 | LSC | | 09/05/2016 | LSC | | |
| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | | LSC | | - | LSC | | |
| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | | | | - | LSC | | |
| ID Prefix | | Correction | ID Prefix | | Correction | ID Prefix | | Correction |
| Reg. # | | Completed | Reg. # | | Completed | Reg. # | | Completed |
| LSC | | | LSC | | - | LSC | | |
| | | | | | | | | |
| REVIEW | | | DATE | SIGNATURE OF | SURVEYOR | | D | ATE |
| STATE A | | (INITIALS) KS/kfd | 9/13/2016 | | 3704 | 1 | | 9/6/2016 |
| REVIEWI CMS RO | | REVIEWED BY (INITIALS) | DATE | TITLE | | | | ATE |
| FOLLOWUP TO SURVEY COMPLETED ON 7/21/2016 | | | | OR ANY UNCORRE | | | | YES 🗌 NO |

| DEPARTMENT OF HEALTH AND HUMAN SERVICES | | | | | CENTERS FOR MEDICARE & MEDICAID SERVICES | | | |
|--|-------------------------------|--|-------------------------|---------------------|--|--|---|--|
| | MEDICA | ARE/MEDICAI | D CERTIFIC | CATION A | AND TRANSMITTAL | I | D: BU2K | |
| | PART I - | TO BE COMPI | LETED BY 1 | THE STAT | TE SURVEY AGENCY | I | Facility ID: 00682 | |
| 1. MEDICARE/MEDICAID PROVID NO.(L1) 245388 | DER | 3. NAME AND AL (L3) LAKESHOP | | | Œ | TYPE OF ACTIO Initial | N: <u>2</u> (L8) 2. Recertification | |
| 2. STATE VENDOR OR MEDICAID (L2) 593043000 | NO. | (L4) 108 8TH ST (L5) WASECA, M | | HWEST | (L6) 56093 | 3. Termination 5. Validation | 4. CHOW 6. Complaint 9. Other | |
| 5. EFFECTIVE DATE CHANGE OF (L9) | OWNERSHIP | 7. PROVIDER/SU 01 Hospital | JPPLIER CATEC 05 HHA | GORY 09 ESRD | <u>02</u> (L7) 13 PTIP 22 CLIA | 7. On-Site Visit 8. Full Survey After | | |
| 6. DATE OF SURVEY 07/2 8. ACCREDITATION STATUS: | 21/2016 (L34) (L10) | 02 SNF/NF/Dual 03 SNF/NF/Distinct | 06 PRTF 07 X-Ray | 10 NF 11 ICF/IID | 14 CORF 0 15 ASC | FISCAL YEAR ENDIN | NG DATE: (L35) | |
| 0 Unaccredited 1 TJC 2 AOA 3 Other | | 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | 12/31 | | |
| 11LTC PERIOD OF CERTIFICATIO | N | 10.THE FACILITY | IS CERTIFIED | AS: | | 1 | | |
| From (a): | | A. In Complia | nce With | | And/Or Approved Waivers Of | The Following Requirement | ents: | |
| To (b): | | | equirements | | 2. Technical Personnel | 6. Scope of Se | rvices Limit | |
| | | - | e Based On: | | 3. 24 Hour RN | 7. Medical Dir | | |
| 12.Total Facility Beds | 55 (L18) | 1. A | cceptable POC | | 4. 7-Day RN (Rural SN | NF) 8. Patient Roor | n Size | |
| 13.Total Certified Beds | 55 (L17) | X B. Not in Con | onliance with Pro | oram | 5. Life Safety Code | 9. Beds/Room | | |
| 13. Total Contined Deas | () | | and/or Applied | | * Code: B | (L12) | | |
| 14. LTC CERTIFIED BED BREAKDO | OWN | | | | 15. FACILITY MEETS | | | |
| 18 SNF 18/19 SNF | 19 SNF | ICF | IID | | 1861 (e) (1) or 1861 (j) (1): | (L15) | | |
| 55 | | | | | | | | |
| (L37) (L38) | (L39) | (L42) | (L43) | | | | | |
| 16. STATE SURVEY AGENCY REM | ARKS (IF APPLICA | BLE SHOW LTC CA | NCELLATION | DATE): | | | | |
| | | | | | | | | |
| 17. SURVEYOR SIGNATURE | | Date : | | | 18. STATE SURVEY AGENCY | APPROVAL | Date: | |
| Susan Kalis, HFE NE II | | 0 | 8/23/2016 | (L19) | K <u>amala Fiske-Downing, Hea</u> | alth Program Represe | <u>ntati</u> ve ^{08/31/2016} (L20) | |
| PA | RT II - TO BE | COMPLETED I | BY HCFA RI | EGIONAI | L OFFICE OR SINGLE S | STATE AGENCY | | |
| 19. DETERMINATION OF ELIGIBII | LITY | | IPLIANCE WIT | H CIVIL | | ncial Solvency (HCFA-257 | | |
| Facility is Eligible to I | Participate | RIGH | ITS ACT: | | Ownership/Control Both of the Above | ol Interest Disclosure Stmt (e : | (HCFA-1513) | |
| Facility is not Eligible | 2 | | | | | | | |
| | (L21) | | | | | | | |
| 22. ORIGINAL DATE | 23. LTC AGREE | MENT 24 | 4. LTC AGREEN | MENT | 26. TERMINATION ACTION | : (| L30) | |
| OF PARTICIPATION | BEGINNING | J DATE | ENDING DA | TE | VOLUNTARY 00 | INVOLUN | TARY | |
| 12/01/1986 | | | | | 01-Merger, Closure | 05-Fail to M | Aeet Health/Safety | |
| (L24) | (L41) | | (L25) | | 02-Dissatisfaction W/ Reimburs | | Meet Agreement | |
| 25. LTC EXTENSION DATE: | 27. ALTERNATI | VE SANCTIONS | | | 03-Risk of Involuntary Termination | on <u>OTHER</u> | | |
| | A. Suspension | n of Admissions: | | | 04-Other Reason for Withdrawal | 07-Provide | r Status Change | |
| (L27) | | | (L44) | | | 00-Active | | |
| (L27) | B. Rescind St | spension Date: | | | | | | |
| | | | (L45) | | | | | |
| 28. TERMINATION DATE: | 29 | . INTERMEDIARY/ | CARRIER NO. | | 30. REMARKS | | | |
| | | 03001 | | | | | | |
| | (L28) | | | (L31) | | | | |
| 31. RO RECEIPT OF CMS-1539 | 32 | 2. DETERMINATION | OF APPROVAI | DATE | | | | |
| | (1.22) | | | (L 22) | | | | |
| | (L32) | | | (L33) | DETERMINATION APP | KUVAL | | |



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 4, 2016

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

RE: Project Number S5388027

Dear Mr. Corchran:

On July 21, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Mankato Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: kathryn.serie@state.mn.us Phone: (507) 476-4233 Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 30, 2016, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by August 30, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

Lakeshore Inn Nursing Home August 4, 2016 Page 3

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Lakeshore Inn Nursing Home August 4, 2016 Page 4

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 21, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

Lakeshore Inn Nursing Home August 4, 2016 Page 5 issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 21, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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

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

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

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525 Lakeshore Inn Nursing Home August 4, 2016 Page 6 Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark meath

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

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

| | | AND HUMAN SERVICES | | | FORI | M APPROVED |
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| | | & MEDICAID SERVICES | 1 | | | 0.0938-0391 |
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| NAME OF F | PROVIDER OR SUPPLIER | | | ST | REET ADDRESS, CITY, STATE, ZIP CODE | |
| LAKESH | ORE INN NURSING H | OME | | | 08 8TH STREET NORTHWEST ASECA, MN 56093 | |
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| F 000 | INITIAL COMMENT | ſS | F 0 | 00 | | |
| | as your allegation of Department's accept enrolled in ePOC, y at the bottom of the | of correction (POC) will serve of compliance upon the otance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. | | | | |
| F 282 SS=D | on-site revisit of you validate that substa regulations has bee your verification. | acceptable electronic POC, an ur facility may be conducted to intial compliance with the en attained in accordance with RVICES BY QUALIFIED ARE PLAN | F 2 | 82 | | 8/25/16 |
| | must be provided b | led or arranged by the facility y qualified persons in ch resident's written plan of | | | | |
| | by: Based on observat review the facility fa developed to maint motion (ROM) for 2 reviewed for range Findings include: R33 was admitted w progressive supran which affects move osteoporosis, diabe Review of the care program, but it was | with diagnoses which included uclear palsy (brain disorder ment), Parkinsonism, etes, anxiety and depression. plan did not identify the ROM identified on the treatment | | | Care plans and CNA flow sheets for both residents were updated to reflect current ROM plan. All other residents were evaluated for current ROM plan and their care plans and CNA flow sheets were updated. The therapy department provided a list of common abbreviations, general instructions for ROM and pictures of several ROM exercises. This information was placed in CNA flow books. | |
| | | ER/SUPPLIER REPRESENTATIVE'S SIGN | NATURE | | TITLE | (X6) DATE |
| Electron | ically Signed | | | | | 08/12/2016 |

Electronically Signed

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

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| | FOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION | | E SURVEY PLETED |
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| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAKESH | IORE INN NURSING H | IOME | | 108 8TH STREET NORTHWEST WASECA, MN 56093 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROI DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 282 | record and flow she document the ROM Review of the med received physical the date of 1/13/16, an The daily treatmen "Patient progress he restorative nursing physical therapy as has been instructed continue under sup this time patient co- dependent on all ca- discomfort in the ri- to a mild level. Patient discontinued (by P with a maintenance under their supervi- The PT discharge identified: Patient/s staff instructed in A- plans and instruction resident of this exter receive a restorative Individualized exer- detailed an exerciss note was provided individualized prog program a handwri- identified PROM B- and Evening. The i- 5 repetitions of eac- with each session. During observation provided bedtime (move her left hand | eet utilized by NAs to <i>A</i> activities. ical record indicated R33 herapy (PT) with a start of care d end of care date of 3/2/16. t note dated 3/2/16, stated has plateaued. Patients program reviewed with ssistant (PTA). Nursing staff d in ROM. This program will bervision of nursing staff. At ntinues to remain completely ares. Patient reports that ght upper arm has decreased tent's treatment supervision T). Nursing staff to continue e range of motion program sion." summary dated 3/2/16, Caregiver Training: Nursing NOM exercises. Discharge ons: Patient will remain a ended care facility and will re nursing program for ROM. cise program to be provided. A for direct care staff with the ram identified. Following the itten note dated 2/25/16, UE and BLEs BID, Morning ndividualized program directed ch exercise to be completed | F 282 | A mandatory CNA inservice will be August 23rd, 2016 and August 25 to train CNA s on proper ROM te and to review general ROM instru CNA s will be instructed on repor refusals of ROM or pain indicators ROM to their charge nurse. CNA also be instructed on importance of following plan of care. DON s will randomly audit 20% of residents weekly times one month monthly times two months to ensu- they are receiving appropriate RO that the staff are following the card Results of audits will be presented November 2016 QA meeting. ROM police revised. | th, 2016 chnique ctions. ting s during s will of of a, then ure that M and e plan. | |

| CENTER STATEMENT AND PLAN C | RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER ORE INN NURSING H SUMMARY STA (EACH DEFICIENCY | AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245388 OME TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | . , | 5 5 10 10 11 | FORM / MB NO. (X3) DATE COMI 07/2 | 08/23/2016 APPROVED 0938-0391 E SURVEY PLETED 21/2016 COMPLETION DATE |
|-----------------------------------|--|--|-----|--------------------------|---|--|
| F 282 | Following the provis dressing in night clo from the toilet utilizi positioned on the si position remained si her chest, and ankli toes pointed. Both N was lying on her ba positioned on the ba rolled cloth in her le hands were in a cur made to remove clo or under fingers. At pillow under R33's alright to provide ex verbalized agreement the upper right arm performing a total of limb. Positioned res R33's cares were cur usual routine for pe stated therapy did the Licensed practical ro on 7/20/16, at 7:55 rigid and needed fu R33 was supposed extremities twice a On 7/20/16, at 1:17 and stated R33 was by staff and a pillow arm and a roll was posed body. Review of the NA fla R33 received ROM | ge 2 sion of personal cares and othes, R33 was transferred ng the stand up lift and was de of the bed. R33's body stiff with head forward toward es pronated downward and NAs positioned R33 so she ck in the bed. Once ed R33 was noted to have a ft hand. The fingers of both fled position. No attempt was oth and/or wash R33's palms 6:34 p.m. NA-B positioned a left arm, and asked if it was sercise at this time. R33 ent and NA-B provided ROM to and both lower legs f three (3) repetitions for each sident for comfort, NA-B stated omplete and this was the rsonal cares and ROM. NA-B he ROM on R33's right arm. nurse (LPN)-A was interviewed a.m. and stated R33 was very Il assist. LPN-A further stated to receive ROM to all day morning and evening. 7 p.m. NA-A was interviewed a positioned in her bed or chair was placed under her left placed into her left hand. received ROM exercises to was not aware of any ROM to be provided for the upper | F2 | 282 | | |

If continuation sheet Page 3 of 23

| | | AND HUMAN SERVICES | | | | FORM | APPROVED 0938-0391 |
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| STATEMENT | TOF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | LE CONSTRUCTION | (X3) DATE | E SURVEY |
| AND PLAN C | OF CORRECTION | IDENTIFICATION NUMBER. | A. BUILDI | ING | i | COM | PLETED |
| | | 245388 | B. WING | | | 07/3 | 21/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAKESH | LAKESHORE INN NURSING HOME | | | | 108 8TH STREET NORTHWEST NASECA, MN 56093 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI) TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 282 | provided in the AM. Request was made and restorative prog provided. Physician orders sig being admitted to the diagnosis including (CVA) with hemiples right side. The quarterly Minim 4/26/16, identified of impairment, extens activities of daily live limitation of upper at admission Care Are 10/27/15, identified CVA (cerebral vasc hemiplegia. Staff pr assistance with all A transferred with a m (physical therapy) at to increase strength Review of the curre sheet identified R2 motion) everyday at note dated 3/30/16, patient from formal week. A PROM (pa program was to cor (RLE) and right upp a strengthening pro R2 also received P 10/15/15, to 12/7/18 Progress & Dischar identified that nursin | e for a policy addressing ROM grams, but nothing was gned 7/19/16, identified R2 as he facility on 10/14/15, with cerebral vascular accident gia (paralysis) affecting the num Data Set (MDS) dated moderate cognitive ive assistance needed with all ing (ADL's) and a functional and lower extremities. The ea Assessment (CAA) dated d R2 as having a history of a ular accident) with right rovided extensive to total ADL's. R2 did not walk, nechanical lift and received PT and OT (occupational therapy) | F 2 | :82 | | | |

If continuation sheet Page 4 of 23

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| LAKESH | IORE INN NURSING H | IOME | | 1 | 08 8TH STREET NORTHWEST | | |
| LARESH | | | | ۷ | WASECA, MN 56093 | | |
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| F 282 | Continued From pa | ige 4 | F 2 | :82 | | | |
| | On 7/20/16, at 7:15 up in wheelchair. R hand. R2 stated it h splint or palm prote assistant (NA)-A go staff didn't do any e On 7/20/15, at 10:0 had previously work affected side to see He stated R2's han time and R2 had re discontinued. He al R2 for a splint prog not have a restorati deemed it appropria physician's order ar On 7/20/16, at 11:1 open his hand it hu NA-B stated staff di | a.m. R2 was observed sitting 2 was unable to open his right nurt if he tried to open it. No actor was in place. Nursing ot R2 up for the day and stated exercises with R2. 8 a.m. COTA-B stated OT ked with R2 with ROM to the a if ROM could be improved. d was not contracted at that eached a plateau so OT was so stated OT did not look at ram. He stated the facility did ive program so if nursing ate they could get a nd evaluate R2 for PT or OT. 0 a.m. NA-B stated, "he can't rts too much." Additionally id not do exercises on R2 "At | | - | | | |
| | happened to it." On 7/20/16, at 12:3 assistant (PTA)-A s maintenance progra right side to preven that PT wrote up a talked to staff to ma with ROM to prever stated, "they should On 7/21/16, at 9:15 done morning cares for him as it is too p | am for ROM mainly for the t contractures. She indicated program for nursing and ake sure they were continuing nt contractures. She also d be doing it daily." a.m. NA-C stated she had s for R2. "We don't do ROM | | | | | |

If continuation sheet Page 5 of 23

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| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAKESH | ORE INN NURSING H | ОМЕ | | 08 8TH STREET NORTHWEST VASECA, MN 56093 | | |
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| F 282 F 309 SS=G | is usually resistive s On 7/21/16, at 10:3 (RN)-A verified R2 s as identified by the NA's learn ROM in they usually did it 5- NA flow sheet shou ROM was being do refusing or staff was nurse should be no A policy on ROM wa provided by the faci 483.25 PROVIDE O HIGHEST WELL BI Each resident must provide the necessa or maintain the high mental, and psycho accordance with the and plan of care. | do a little ROM on him but he so I don't do it." 0 a.m. registered nurse should be receiving ROM daily flow sheet. She stated the NA class. RN-A further stated -10 minutes. She stated the Id have identified where the ne. RN-A stated if R2 was s not completing the ROM the tified. as requested but none was lity. CARE/SERVICES FOR | F 282 F 309 | R2 was set up on Tylenol 500mg per routinely and daily | o bid | 8/22/16 |
| | provide adequate p (R2) reviewed for p R2 as he experienc on a daily basis that untreated. Therapy | iled to assess pain and ain control for 1 of 1 residents ain. This resulted in harm for ed moderate to severe pain t remained unassessed and notes identify R2 had g back to date of admission. | | routinely and daily pain assessments set up. NP will re pain on August rounds. Order obtained for therapy evaluation. R2 s care plan updated to include pain interve Facility pain policy was reviewed and updated. | | |

Facility ID: 00682

If continuation sheet Page 6 of 23

| STATEMENT | OF DEFICIENCIES | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION | (X3) DAT | <u>. 0938-039</u> E SURVEY IPLETED | | |
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| ND PLAN (| F CORRECTION | IDENTIFICATION NOMBER. | A. BUILD | ING | COM | IFLETED | | |
| | | 245388 | B. WING | | | 21/2016 | | |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, Z | | ODE | | |
| LAKESH | ORE INN NURSING H | IOME | | 108 8TH STREET NORTHWEST WASECA, MN 56093 | | | | |
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| F 309 | Continued From pa | age 6 | F 3 | 809 | | | | |
| | was admitted to the diagnosis including (CVA) with hemiple side and expressiv express language). The quarterly Minin 4/26/16, identified impairment, extens activities of daily liv limitation of upper a admission Care Ard 10/27/15, identified CVA with right hem extensive to total a did not walk, transf and received PT (p (occupational thera mobility. During observation was observed to gr arm/hand was touc it. P2 was observe with his left hand a asked if it hurt he m On 7/20/16, at 7:15 up in the wheelcha right hand. R2 state On 7/20/16, at 11:0 sitting up in the whe clenched. When a he shook his head | gned 7/19/16, identified R2 e facility on 10/14/15, with a cerebral vascular accident egia (paralysis) affecting right e aphasia (loss of the ability to num Data Set (MDS) dated moderate cognitive sive assistance needed with all ring (ADL's) and a functional and lower extremities. The ea Assessment (CAA) dated d R2 as having a history of a iplegia. Staff provide ssistance with all ADL's. R2 erred with a mechanical lift shysical therapy) and OT apy) to increase strength and on 7/19/16, at 6:00 p.m. P2 rimace any time the right shed or he attempted to move d to lift his right hand/arm up nd stated "Ouch!" When nodded his head yes. 5 a.m. R2 was observed sitting ir. R2 was unable to open his ed it hurt if he tried to open it. 00 a.m. R2 was observed eelchair. R2 had his right hand sked if he could open his hand no and indicated it hurt if he n was lightly touched, R2 | | A nurses meeting will be 22, 2016 to review the facility s pain policy. Pain management education nurses stations for CNA s to review. CNA report pain indicators (verbal and no charge nurse. Pain assessments will be upon admission and upon recognition of disco assessment, nursing staff will determin medications should be given and if ph be notified. DON s will randomly au residents weekly times for one month, then monthly months to determine if they are experiencing pa pain regime is appropriate. The results of audits will November 2016 QA meeting. | a management materials put at s instructed to on verbal) to their e administered omfort. Based on ne whether pain hysician needs to adit 20% of or y times two ain and if current | | | |

If continuation sheet Page 7 of 23

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED . 0938-0391 |
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| | | 245388 | B. WING | | | 07/ | 21/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAKESH | ORE INN NURSING H | ОМЕ | | | 108 8TH STREET NORTHWEST WASECA, MN 56093 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRC DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 309 | grimaced. On 7/20/16, at 12:4 therapist registered the dining room. Wi right arm/hand, he g stated "ouch!" OTF R2 in occupational | ge 7 47 p.m. OTRL (occupational licensed)-A observed R2 in hen OTRL-A touched R2's grimaced with pain and loudly RL stated she had worked with therapy (OT) in the fall and 2's right side was very | F3 | 309 | | | |
| | sensitive. On 7/20/16, at 2:29 in the dining room v attempted to lift his hand. R2 was obse if it hurt, he nodded stated, "it does real On 7/21/16, at 8:32 in the dining room. arm/hand, he shrug unable to open his 1 to lift arm/hand he g On 7/21/16, at 10:0 (NA)-E and NA-F w (mechanical lift dev NA-F attempted to | p.m. R2 was observed sitting vith his wife. His wife right arm/hand to look at his rved to grimace. When asked his head yes. R2's wife ly seem to hurt him." a.m. R2 was again observed When asked about his right ged his shoulders. R2 was hand and when he attempted grimaced and expressed pain. 9 a.m. nursing assistant ere observed using the EZ lift ice) to lay R2 in bed. When lift his right arm to hold onto out, "No! No! Ouch! Ouch!" | | | | | |
| | NA-F asked R2 wha stated "7" (on a sca most pain). Review of the medi received OT from 1 included: 10/29/16 - [R2] was splint on therapist a | at his pain level was and R2 le of 0-10 with 10 being the cal record identified R2 had 0/15/15 to 12/8/15. OT notes a not wearing right resting rrival. Pt presents with contracture/limited PROM | | | | | |

If continuation sheet Page 8 of 23

PRINTED: 08/23/2016

| STATEMENT | OF DEFICIENCIES | KIDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · / | | ONSTRUCTION | (X3) DAT | <u>. 0938-039</u> E SURVEY IPLETED |
|--------------------------|---|---|--------------------|------|--|----------|--|
| | | 245388 | B. WING | | | 07/ | 21/2016 |
| NAME OF | PROVIDER OR SUPPLIER | | | STRE | ET ADDRESS, CITY, STATE, ZIP CODE | 017 | 21/2010 |
| LAKESH | ORE INN NURSING H | IOME | | | 8TH STREET NORTHWEST SECA, MN 56093 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETIC DATE |
| F 309 | (passive range of r extremity). 11/3/15 - [R2] care and daughters. Ma including RUE pair 11/9/15 - PROM ve pain and refusing. 11/16/15 - [R2] had and forearm today. 11/20/15 - [R2] con 11/23/15 - PROM F complaints of pain. 11/25/15 - did not v with movement wit 11/26/15 - PROM v pain, OT only able 11/27/15 - [R2] has caused pain in RU 12/2/15 - Limited P due to pain. 12/8/15 - noted right tolerated gentle PF 12/8/15 - Therapists Summary dated ider right hand to sever hand to mild on 11, mild but demonstration verbalizations durin moderate on 12/8/ Review of the med (MAR) from April 2 had an order for Ty every 4 hours as n Documentation ind 500 mg once in Ap 2016, 6 times in Ju 2016. Review of the | notion) in RUE (right upper conference was held with wife any concerns were discussed n management. ery limited due to [R2] reporting d significant pain in right hand nplained of discomfort at times. RUE with limited ROM and verbalize pain but grimaced h PROM. with maximum complaints of to do minimal ROM. s stiff digits and extension E. PROM as [R2] would not allow ht hand joint contracture, [R2] ROM. t Progress & Discharge entified [R2] reports pain in e on 10/29/15, pain in right /25/15 and pain in right hand to ated facial grimaces and ng ROM to indicate pain is | F 3 | 309 | | | |

If continuation sheet Page 9 of 23

| | | AND HUMAN SERVICES | | | | FORM | 08/23/2016 APPROVED 0938-0391 |
|--------------------------|---|--|---------------------|----|---|----------|-------------------------------------|
| STATEMENT | T OF DEFICIENCIES DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | E CONSTRUCTION | (X3) DAT | E SURVEY IPLETED |
| | | 245388 | B. WING _ | | | 07/3 | 21/2016 |
| NAME OF | PROVIDER OR SUPPLIER | • | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAKESH | IORE INN NURSING H | IOME | | | 08 8TH STREET NORTHWEST /ASECA, MN 56093 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | ¢ | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 309 | given 3 times for ar times for pain. Nur 5/24/16, R2 compla- identified a pain lew being worst pain). C complaints of pain 15/29/16, R2 had ex pain level of 5. On 6 "all over" and a pain again complained of pain at a level 5. On pain "all over" and r 6/6/16, R2 complain his pain level as 6. over" and rated his R2 had pain "all ove 5. The Pain Managem identified the facility identifying the inten (5 as the highest ar was the facility polid utilize this scale as pain greater than 5. with the PRN Tylen was used or the lew administration of Ty assessment, there acceptable level of was unclear what F movement, at rest, movement. The care plan dated mobility due to histo accident with right f approach of "assure | n elevated temperature and 9 sing notes identified on ained of pain "all over" and had el of 5 of 10 (0 not pain, 10 On 5/26/16, R2 had "vocal (that hurts, ouch, stop). On pressed pain "all over" and a 5/1/16, R2 complained of pain n level of 4. On 6/2/16, R2 of pain "all over" and rated the n 6/3/16, R2 complained of rated the pain level as 5. On ned of pain "all over" and rated On 6/11/16, R2 had pain "all pain level as 4. On 6/12/16, er" and rated the pain level as nent Policy revised 8/03, y pain protocol included sity of pain using a 0-5 scale mount of pain). Although this cy, staff did not consistently evidenced by R2 rating his . There was no documentation of to identify what pain scale rel of relief obtained with the venol. Further, without a pain was no evidence of what an pain was for R2. In addition, it 82's level of pain was with and at rest following | F 3 | 09 | | | |

If continuation sheet Page 10 of 23

| | | I AND HUMAN SERVICES E & MEDICAID SERVICES | | | | FORM | 08/23/2016 APPROVED 0938-0391 |
|--------------------------|---|---|-------------------|-----|---|-----------|-------------------------------------|
| STATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | | (X3) DATI | E SURVEY IPLETED |
| | | 245388 | B. WING | ì | | 07/ | 21/2016 |
| NAME OF | PROVIDER OR SUPPLIER | | - | | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAKESH | IORE INN NURSING H | IOME | | | 108 8TH STREET NORTHWEST NASECA, MN 56093 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETION DATE |
| F 309 | identified. Without a for pain, there were management appro On 7/20/16, at 11:1 open his hand it hui On 7/21/16, at 9:15 morning cares for F ROM for him as it is really complained o right side. NA-C sta pain is more than u was aware that it bo On 7/21/16, at 10:0 "sometimes I try to is usually resistive to do it." On 7/21/16, at 9:40 (LPN)-A stated the stated he had pain. doesn't like anyone On 7/21/16, at 11:0 (RN)-B verified a pain been completed on been reporting increa The Pain Managem identified it was fact amount of pain a re to evaluate the ana pain protocol includ pain using a 0-5 sca of pain), analgesic to efficacy of pharmac | a comprehensive assessment e no individualized pain baches identified for R2. 0 a.m. NA-B stated, "he can't irts too much." 5 a.m. NA-C stated she did R2. She stated, "we don't do s too painful." She stated R2 of pain when staff try to lift his ated she let the nurse know if isual. She stated the nurse othered him to move too fast. 08 a.m. NA-D stated, do a little ROM on him but he because it hurts him so I don't 0 a.m. licensed practical nurse aides had not reported R2 . She stated "I think he just e touching that arm." 00 a.m. registered nurse ain assessment should have n R2 and staff should have eased pain to nurse. nent Policy revised 8/03, dility policy to assess the esident was experiencing and digesic prescribed. The facility ded identifying the intensity of ale (5 as the highest amount used, plan and comments and | F | 309 | | | |

Facility ID: 00682

If continuation sheet Page 11 of 23

| | | AND HUMAN SERVICES | | | FORM | : 08/23/201 APPROVEI . 0938-039 | | |
|--------------------------|--|--|---------------------------------------|---|--|---------------------------------------|--|--|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | IPLE CONSTRUCTION | (X3) DAT | (X3) DATE SURVEY COMPLETED | | |
| | | 245388 | B. WING _ | | 07/ | 07/21/2016 | | |
| NAME OF F | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | | | |
| LAKESH | ORE INN NURSING H | ЮМЕ | | 108 8TH STREET NORTHWEST WASECA, MN 56093 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD BI | | (X5) COMPLETION DATE | | |
| F 309 | also indicated an ongoing pain management plan | | F 30 | 09 | | | | |
| F 318 SS=D | would be addressed on the resident's care plan. 483.25(e)(2) INCREASE/PREVENT DECREASE | | F 3 ⁻ | 18 | | 8/25/16 | | |
| | | | | | | | | |
| | by: Based on observat review the facility fa motion (ROM) serv mobility for 2 of 3 re for range of motion Findings include: R33 was admitted w progressive supran which affects move osteoporosis, diabe Review of the medi received physical the date of 1/13/16, and The daily treatment "Patient progress h restorative nursing physical therapy as has been instructed continue under sup this time patient con dependent on all ca | NT is not met as evidenced tion, interview and document alled to provide range of ices to maximize strength and esidents (R33, R2) reviewed services. with diagnoses which included uclear palsy (brain disorder ment), Parkinsonism, etes, anxiety and depression. cal record indicated R33 herapy (PT) with a start of care d end of care date of 3/2/16. In the dated 3/2/16, stated as plateaued. Patients program reviewed with sistant (PTA). Nursing staff d in ROM. This program will ervision of nursing staff. At ntinues to remain completely ares. Patient reports that ght upper arm has decreased | | Physicians for R2 and R33 we contacted and orders were ob- therapy evaluations. Both resi- plans and CNA flow sheets we to reflect the current range of r All residents were evaluated for range of motion plan. Change made as needed. Physicians obtained for residents that nee- evaluations. All care plans an- sheets were updated to includ ROM plans. The therapy department provise common abbreviations, genera- instructions for ROM and pictu- several ROM exercises. This was placed in all the CNA flow When a resident is discharged therapy, the therapy manager | tained for idents care ere updated motion plan. or current es were orders were eded PT/OT d CNA flow e current ded a list of al ures of information books. | | | |

Facility ID: 00682

PRINTED: 08/23/2016

| | <u>RS FOR MEDICARE</u> OF DEFICIENCIES | & MEDICAID SERVICES | | LE CONSTRUCTION | | 0938-039 SURVEY | |
|--------------------------|---|---|---------------------|---|--|---------------------------|--|
| | OF DEFICIENCIES OF CORRECTION | IDENTIFICATION NUMBER: | | | · · · | PLETED | |
| | | 245388 | B. WING | | 07/2 | 21/2016 | |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| LAKESH | ORE INN NURSING H | IOME | | 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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETIO DATE | |
| F 318 | to a mild level. Pati- discontinued (by P ⁻ with a maintenance under their supervis PT daily treatment 2/16/16: received p (PROM) with end s extremities(BUE) a (BLE) to improve R positioning and con 2/18/16: Resident Tolerated PROM to range stretch to all 10 repetitions. Acti at fingers, wrist, elb repetitions. Tolerat current plan of care decrease pain. 2/24/16: Patient re and AROM RUE ar Instructed nursing a and AROM program discharge patient to on a PROM program 2/25/16: Instructed identified), in PROM once in the a.m. be once in p.m. before night nurse regardin The PT discharge s identified: Patient/0 staff instructed in A plans and instructio resident of this exter receive a restorativ Individualized exercise | ent's treatment supervision T). Nursing staff to continue a range of motion program sion." notes identified: assive range of motion tretch bilateral upper nd bilateral lower extremities OM for wheelchair (W/C) nfort. reports PROM feels good. BUE and BLE with gentle end joints and resident tolerance x ve ROM (AROM) to right UE bow and shoulder x 10 ed session well. Continue with a to increase ROM and ceived PROM LLE AND LUE nd RLE with end stretch. assistant (NA)[-B] in PROM ns. Discussed the plan to b a restorative nursing program | F 318 | ROM needs with the DON s and nurse, and a program will be implat that time if necessary. A mandatory CNA inservice will b August 23rd, 2016 and August 25 to train on proper ROM technique review general ROM instructions. will be educated on reporting refuered ROM or pain indicators during ROM or pain indicators during ROM or pain indicators during ROM or esidents weekly times one month monthly times two months to ensithey are receiving appropriate ROM that the staff are following the car Results of audits will be presentered November 2016 QA meeting. Range of motion police revised. | e held on th, 2016 s and to CNA s sals of DM to of n, then ure that DM and e plan. | | |

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTI | PLE CONSTRUCTION | · · · | TE SURVEY | | |
|--------------------------|--|---|---------------------|---|----------|---------------------------|--|--|
| ND PLAN (| OF CORRECTION | IDENTIFICATION NUMBER: | A. BUILDIN | G | 00 | MPLETED | | |
| | | 245388 | B. WING | | 07 | //21/2016 | | |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI | DDE | | | |
| AKESH | ORE INN NURSING | HOME | | 108 8TH STREET NORTHWEST WASECA, MN 56093 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETIC DATE | | |
| F 318 | Continued From p | age 13 | F 31 | 8 | | | | |
| | identified PROM B and Evening. The 5 repetitions of eac with each session. During observation provided bedtime of not observed to as transfer from chain was utilized. R33 of arm and it remained held against her bo and assisted with y and NA-C assiste body. R33's right a movement. Follow cares and dressing transferred from th and was positioned body position remain toward her chest, a and toes pointed. If she was lying on h positioned on the b rolled cloth in her I hands were in a cu made to remove c or under fingers. A pillow under R33's alright to provide e verbalized agreem upper right arm an total of three (3) re Positioned residen | n on 7/19/16, at 6:03 p.m. NA-B (HS) care for R33. R33 was asist with position changes or to toilet or bed and a stand lift did not move her left hand or ed in an elbow bent position, ody. NA-C came into the room washing resident. Both NA-B d with dressing R33's upper arm was stiff and resistant to ing the provision of personal g in night clothes, R33 was he toilet utilizing the stand up lift d on the side of the bed. R33's ained stiff with head forward and ankles pronated downward Both NAs positioned R33 so her back in the bed. Once bed R33 was noted to have a eft hand. The fingers of both urled position. No attempt was loth and/or wash R33's palms at 6:34 p.m. NA-B positioned a left arm, and asked if it was exercise at this time. R33 hent and NA-B provided ROM to d both lower legs performing a epetitions for each limb. at for comfort, NA-B stated complete and this was the | | | | | | |

Facility ID: 00682

If continuation sheet Page 14 of 23

| | | AND HUMAN SERVICES | | | | FORM | 08/23/2016 APPROVED 0938-0391 |
|--|---|---|-------------------|-----|---|----------|-------------------------------------|
| STATEMENT OF DEFICIENC AND PLAN OF CORRECTION | IES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ` ' | | PLE CONSTRUCTION | (X3) DAT | E SURVEY PLETED |
| | | 245388 | B. WING | i | | 07/3 | 21/2016 |
| NAME OF PROVIDER OR S | SUPPLIER | • | | e, | STREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAKESHORE INN NU | RSING H | IOME | | | 108 8TH STREET NORTHWEST WASECA, MN 56093 | | |
| PREFIX (EACH D | EFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| (ADLs) and full assist. I supposed t a day morn reported the discussed a 7/18/16. It tear on the this was the and R33's i On 7/20/16 and stated by staff and arm and a NA-A indict her lower b that was subody. Review of t R33 receiven nothing was provided in Review of t program, b record and document t Request wa and restora provided. Physician of was admitted diagnoses (CVA) with right side. | ance wit I that she _PN-A fu o receiv ing and e decline at the m was also posteric bught to inability f , at 1:17 R33 was d a pillow roll was ed R33 ody but upposed he NA fl ed ROM s docum the AM. he care ut it was flow she at the ROM as made at the pro- orders si ed to the including hemiple | h activities of daily living e was very rigid and needed wither stated R33 was e ROM to all extremities twice evening. In addition LPN-A e in ADL status had been ost recent care conference on o indicated R33 had a skin or surface of her left hand and be the result of using the lift to grip with her left hand. 7 p.m. NA-A was interviewed s positioned in her bed or chair v was placed under her left placed into her left hand. received ROM exercises to was not aware of any ROM to be provided for the upper ow sheet for 7/16 indicated exercise in the PM but tented as having been plan did not identify the ROM identified on the treatment bet utilized by NAs to | F | 318 | 3 | | |

If continuation sheet Page 15 of 23

| CENTER STATEMENT AND PLAN C | RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION PROVIDER OR SUPPLIER ORE INN NURSING H SUMMARY STA (EACH DEFICIENCY | AND HUMAN SERVICES AND HUMAN SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245388 IOME TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | | S 10 N | | FORM / MB NO. (X3) DATE COMI 07/2 | 08/23/2016 APPROVED 0938-0391 E SURVEY PLETED 21/2016 (X5) COMPLETION DATE |
|-----------------------------------|---|---|----|--------------|-------------|---|--|
| F 318 | impairment, extensi activities of daily livi limitation of upper a admission Care Are 10/27/15, identified CVA (cerebral vasci hemiplegia. Staff pr assistance with all A transferred with a m (physical therapy) a to increase strength Review of the curre sheet identified R2 motion) everyday as note dated 3/30/16, patient from formal week. A PROM (pa program was to cor (RLE) and right upp a strengthening pro R2 received occupa 10/15/15, to 12/8/15 identified : 10/26/15, mild to main in hand. A trial of a initiated to maintain further contracture. 10/29/15, pt was no and significant cont noted in the RUE. I splint R2 had from a the splint did not ad temporary resting s hand. 11/2/15, a new resti The splint that was | ive assistance needed with all ing (ADL's) and a functional and lower extremities. The ea Assessment (CAA) dated d R2 as having a history of a ular accident) with right rovided extensive to total ADL's. R2 did not walk, nechanical lift and received PT and OT (occupational therapy) n and mobility. ent nursing assistant care was receiving ROM (range of s tolerated, slow/gentle. A PT , indicated a plan to discharge physical therapy by end of this assive range of motion) ntinue for right lower extremity ber extremity (RUE) as well as ogram for maintenance. ational therapy (OT) from 5. Review of the OT notes oderate contractures present right resting splint was a skin integrity and prevent | F3 | 318 | DEFICIENCY) | | |

If continuation sheet Page 16 of 23

| | | AND HUMAN SERVICES | | | | FORM | 08/23/2016 APPROVED 0938-0391 | |
|---|--|---|--|-----|---|-------------------------------|-------------------------------------|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
| | | 245388 | B. WING | | | 07/2 | 21/2016 | |
| NAME OF I | PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE | | | |
| LAKESH | ORE INN NURSING H | IOME | 108 8TH STREET NORTHWEST WASECA, MN 56093 | | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | ID PREF TAG | IX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 318 | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 11/3/15, a care conference was held at which time "many concerns were discussed, including OT interventions regarding splinting and RUE pain management." 11/4/15, a splint was again applied to R2's arm/hand. 11/10/15, it was noted R2 needed daily PROM to allow for hygiene and maintain skin integrity to RUE. 11/12/15, a new right resting splint was applied. Photos were taken for staff instruction and a wearing schedule was discussed with the COTA (certified occupational therapy assistant) staff who would monitor status later in the day. 11/16/15, the right nesting splint was applied and to be removed after 2 hours of wearing the splint. 11/18/15, the right hand splint was applied without difficulty. Splint was noted to be on 11/22/15. 11/22/15 to 11/30/15, no mention of splint placement was noted. 11/30/15, PROM was completed to right hand. Hand was noted to be very tight and patient's fingernails were long. OT attempted to don right resting hand splint but was unable to apply. 12/3/15, a palm protector was applied to right hand. Pt refused the functional hand splint. Nursing staff was educated on the palm protector and in agreement with the plan. 12/4/15, R2 was noted to be wearing the palm protector. 12/7/15, pt had on a splint that therapy did not provide, the splint was not working and the COTA removed it. Review of the OT - Therapist Progress & Discharge Summary dated 12/8/15, identified a goal on 10/29/15, of "Caregiver appropriately don, doff right resting splint orthotic to monitor skin condition for effective skin and joint | | F | 318 | 3 | | | |

If continuation sheet Page 17 of 23

| | - | AND HUMAN SERVICES | | | FORM | 08/23/2016 APPROVED 0938-0391 |
|--|--|--|---------------------|--|---|-------------------------------------|
| CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | . , | E CONSTRUCTION | MB NO. 0938-0391 (X3) DATE SURVEY COMPLETED | |
| | | 245388 | B. WING | | 07/2 | 21/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAKESH | ORE INN NURSING H | OME | | 08 8TH STREET NORTHWEST VASECA, MN 56093 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 318 | protection and cont goal was identified R2 also received P 10/15/15, to 12/7/15 Progress & Dischar identified that nursin maintenance range On 7/20/16, at 7:15 up in wheelchair. R hand. R2 stated it h splint or palm prote assistant (NA)-A go staff didn't do any e On 7/20/15, at 10:0 had previously work affected side to see He stated R2's han time and R2 had re discontinued. He al R2 for a splint prog not have a restorati deemed it appropria physician's order ar On 7/20/16, at 11:1 open his hand it hu NA-B state staff did one time he had a b happened to it." | racture management" This as being met on 12/8/15. T (physical therapy) from 5. Review of the PT Therapist rge Summary dated 12/7/15, ng staff was instructed in a of motion program. a.m. R2 was observed sitting 2 was unable to open his right nurt if he tried to open it. No ctor was in place. Nursing it R2 up for the day and stated exercises with R2. 8 a.m. COTA-B stated OT ked with R2 with ROM to the of ROM could be improved. d was not contracted at that ached a plateau so OT was so stated OT did not look at ram. He stated the facility did ve program so if nursing | F 318 | | | |

Facility ID: 00682

If continuation sheet Page 18 of 23

| | | AND HUMAN SERVICES | | | | | FORM | 08/23/2016 APPROVED 0938-0391 |
|----------------------------|---|---|--|-----------------------------|--|------|-------------------------------|-------------------------------------|
| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | | (X3) DATE SURVEY COMPLETED | |
| 245388 | | 245388 | B. WING | | | | 07/21/2016 | |
| NAME OF F | PROVIDER OR SUPPLIER | • | | | SS, CITY, STATE, ZIP CODE | Ξ | | |
| LAKESHORE INN NURSING HOME | | | | 108 8TH STREE WASECA, MN | ET NORTHWEST I 56093 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | (EACH | VIDER'S PLAN OF CORRE CORRECTIVE ACTION SHO REFERENCED TO THE APP DEFICIENCY) | OULD | BE | (X5) COMPLETION DATE |
| F 318 | wife brought in a sp one, she did not rer not. On 7/20/16, at 12:3 assistant (PTA)-A s maintenance progra right side to preven that PT wrote up a talked to staff to ma with ROM to prever stated, "they should On 7/20/16, at 2:29 interviewed. She si for him at home and facility. However, sh good idea. On 7/21/16, at 9:15 done morning cares for him as it is too p On 7/21/16, at 10:0 "sometimes I try to is usually resistive s On 7/21/16, at 10:3 (RN)-A verified R2 s as identified by the NA's learn ROM in they usually did it 5 NA flow sheet shou ROM was being do refusing or staff wa nurse should be no OT had recommend | was before. She thought his blint but they tried a different member if it worked for R2 or 37 p.m. physical therapy stated R2 was on a am for ROM mainly for the t contractures. She indicated program for nursing and ake sure they were continuing nt contractures. She also d be doing it daily." 9 p.m. R2's wife was tated she never had a splint d had not brought one to the he thought that would be a 5 a.m. NA-C stated she had s for R2. "We don't do ROM painful." | F 31 | 8 | DEFICIENCY) | | | |

Facility ID: 00682

If continuation sheet Page 19 of 23

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | F | ORM | 08/23/2016 APPROVED 0938-0391 |
|--------------------------|---|---|-------------------|--------------------|---|--|-------------------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION (X3 | (X3) DATE SURVEY COMPLETED | | |
| | | 245388 | B. WING | i | | 07/21/2016 | |
| NAME OF F | PROVIDER OR SUPPLIER | | - | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAKESH | ORE INN NURSING H | ОМЕ | | | 08 8TH STREET NORTHWEST VASECA, MN 56093 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | Ē | (X5) COMPLETION DATE |
| F 318 | Continued From pa communicated and | ge 19 placed on the NA flow sheets. | F | 318 | | | |
| F 465 SS=E | provided by the fac 483.70(h) | as requested but none was llity. \L/SANITARY/COMFORTABL | F٠ | 465 | | | 9/5/16 |
| | | ovide a safe, functional, ortable environment for the public. | | | | | |
| | by: Based on observat review, the facility f | NT is not met as evidenced ion, interview, and document ailed to maintain a clean, nt, and resident rooms in good residents. | | | Since the survey, we have created a "maintenance room check list". Each room has a checklist that will be review at least annually, and more often as needed, or communicated to our maintenance staff. | wed | |
| | 7/18/16, and verifie with the environment follows: 1. R1's bathroom we bulged outward alo was cracked open, wet, substance that The paint and surfar moist and easily cru The opening was a and gapped 4 inchest identified that she r 4/16, but no repairs | I during the initial tour on d on 7/21/16, at 12:50 p.m. ntal director (ED) were as vall was damaged, the wall ng the floor board. The wall and revealed a black, loose, was visible inside the wall. ice around the opening was umbled away when touched. pproximately 18 inches long es. Family member (FM)-A eported the damaged wall in had been completed. While verified he was aware of the | | | Dining room problem areas have been addressed - painted, touched up, clea and frosted (Plexiglas). Resident room where properly identified on the reside list provided to us by the survey team, have had holes patched, door frames painted, sheet rock repaired, restroom repaired as well. Without knowing all of the residents sited in the 2567, we can guarantee that all items have been rectified, but we believe we have fixed of the items on the list. All rooms will be checked, using the m checklist, by 8/31/16. Work will be dor as deemed necessary and work shall | ned ns, ent ns of nnot I all ew ne | |

| | | | | | | 0938-039 |
|--------------------------|--|---|---------------------|--|--------------------------|---------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | PLE CONSTRUCTION G | | E SURVEY IPLETED |
| | | 245388 | B. WING | | 07/ | 21/2016 |
| NAME OF | PROVIDER OR SUPPLIER | • | | STREET ADDRESS, CITY, STATE, ZIP CO | DE | |
| LAKESH | ORE INN NURSING H | IOME | | 108 8TH STREET NORTHWEST WASECA, MN 56093 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| F 465 | damaged wall. 2. R57's bathroom The white tiles with were discolored. 3. R20's bathroom could be detected a 4. R14's bathroom smell which seeme entryway to the room noted to be heavily and surface damag 5. R1's bathroom h were 1 to 2 inch hol bathroom walls, esp sink. The door fram bathroom, were heavily revealed paint remo 7. R13's room reve were in need of rep were marked with b bathroom door fram marks and the surfa damaged. 8. R45's wall on the a 2 inch gouge to th surface was heavily 9. R39's ceiling tile across the tile. 10. R41's wall behi covering an area 4 | had a pungent foul urine odor. grout had black debris and had a strong urine odor that at the entry door to the room. had a strong malodorous d to concentrate by the m. The bathroom door was scraped, with missing paint ge. had a strong urine odor. There les and gouges noted on the pecially prevalent around the hes to the room, and to the avily scraped, with paint and entry door frames, were scraped with black marks and oved and surface damage. ealed holes in the wall, that hair. The walls in the room black marks. The entry and hes, were marked with black ace was heavily scraped and e left side of the window, had he sheet rock, the paint and | F 46 | 5 completed by 9/5/16. Director of Maintenance will r QA committee the progress of update the committee on the "maintenance room check list | f work and use of the | |

If continuation sheet Page 21 of 23

| | | AND HUMAN SERVICES | | | | FORM | 08/23/2016 APPROVED 0938-0391 |
|--------------------------|---|--|-------------------|-----|---|----------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | PLE CONSTRUCTION | (X3) DAT | E SURVEY PLETED |
| | | 245388 | B. WING | i | | 07/ | 21/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | | | 5 | STREET ADDRESS, CITY, STATE, ZIP CODE | - | |
| LAKESH | ORE INN NURSING H | IOME | | | 108 8TH STREET NORTHWEST WASECA, MN 56093 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) |) BE | (X5) COMPLETION DATE |
| F 465 | moved in a year ag bathroom had a bui was stained, brown away when touched door frames, were s were heavily scraped 12. The lower 3 fee heavily scraped, bla paint was missing. surface damaged, a revealing the sheet Plexiglass walls sur area were stained, and surface damage During the tour the a quarterly schedule. housekeeping staff bathroom daily. He existed, and turned fans during the tour housekeepers were repairs were neede ED presented a clip communication, wh issues in need of re the communication Review of the policy Housekeeping Infed included patient bat every six months w dated as revised 1/ Policy identified rou to be performed da | o. The corners of the ild up of debris, and the grout and yellow and crumbled d. The bathroom and entry stained, had black marks, and ed with surface damage. t of the dining room walls were ack marks were evident, and Sections of wall paper were and releasing from the wall rock underneath. The rrounding the coffee serving and the surface was scraped, jed. ED stated at 1:30 p.m. he had e to make the necessary tirs (e.g., walls, floors, tile). test he was unable to submit The ED stated the cleaned each room and was unsure why the odors on three bathroom exhaust r. The ED stated the e responsible to report when ed. When in the west wing the potential expair. There were no notes on the expansion of the end of | F 4 | 465 | | | |

If continuation sheet Page 22 of 23

| | | AND HUMAN SERVICES | | | | FORM | 08/23/2016 APPROVED 0938-0391 |
|--------------------------|---|---|--------------------|-----|--|-------------------------------|-------------------------------------|
| STATEMENT | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 245388 | B. WING | | | 07/2 | 21/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | | • | | TREET ADDRESS, CITY, STATE, ZIP CODE | • | |
| LAKESH | ORE INN NURSING H | IOME | | | 08 8TH STREET NORTHWEST VASECA, MN 56093 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 465 | on the East Wing. S contact maintenance something needed semi-annual basis, housekeeping depa room floors, mainter rooms to repair any The checklist include | ed in the South Wing and one Staff nurses were instructed to ce staff immediately if to be repaired sooner. On a | F 4 | 465 | | | |

Facility ID: 00682

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

PRINTED: 08/15/2016 FORM APPROVED OMB NO. 0938-0391

| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01 | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|---|--------------------|--|-------------------------------|
| | | 245388 | B. WING | | 07/21/2016 |
| | PROVIDER OR SUPPLIER ORE INN NURSING H | IOME | | STREET ADDRESS, CITY, STATE, ZIP CODE 108 8TH STREET NORTHWEST WASECA, MN 56093 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE COMPLETION |
| K 000 | INITIAL COMMEN | TS | ĸ | 00 | |
| | FIRE SAFETY | | | | |
| | ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT T | OC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE. | | | |
| | ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CC REGULATIONS H/ | OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION. | | | |
| | Minnesota Departm Fire Marshal Divisi dated July 21, 2010 Home was found n with the requireme Medicare/Medicaid 483.70(a), Life Saf edition of National | Survey was conducted by the nent of Public Safety - State on. At the time of this survey 3, Lakeshore Inn Nursing tot in substantial compliance nts for participation in I at 42 CFR, Subpart ety from Fire, and the 2000 Fire Protection Association I01, Life Safety Code (LSC), g Health Care. | | | |
| | PLEASE RETURN CORRECTION FC DEFICIENCIES (K-TAGS) TO: | THE PLAN OF OR THE FIRE SAFETY | | EPOC | |
| | Health Care Fire Ir State Fire Marshal 445 Minnesota St., St Paul, MN 55101 | Division Suite 145 | | | |
| | Y DIRECTOR'S OR PROVI | DER/SUPPLIER REPRESENTATIVE'S SIG | NATURE | TITLE | (X6) DATE 08/12/2016 |

Electronically Signed

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

Facility ID: 00682

| CENTER | KS FOR MEDICARE | & MEDICAID SERVICES | | | | . 0938-039 |
|--------------------------|---|---|---------------------|---|----------|---------------------------|
| | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (, , | LE CONSTRUCTION 6 01 - MAIN BUILDING 01 | | TE SURVEY MPLETED |
| | | 245388 | B. WING | | 07 | /21/2016 |
| NAME OF | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP COI | DE | |
| LAKESH | ORE INN NURSING H | IOME | | 108 8TH STREET NORTHWEST WASECA, MN 56093 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETIO DATE |
| K 000 | DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defic 2. The actual, or pr 3. The name and/or responsible for cor- prevent a reoccurred Lake Shore Inn Nu- building with a part constructed at 4 dif building was constru- determined to be on 1968, addition was that was determined construction. In 197 added to the South- be Type II (111). In to the East Wing a II (111) construction and the 3 additions construction and m allowed for existing surveyed as one but The building is fully fire alarm system v corridors and space | Atate.mn.us and m@state.mn.us RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. roposed, completion date. roposed, completion date. rop | κ οος | | 7 | |

PRINTED: 08/15/2016

| GENTER | KS FOR MEDICARE | & MEDICAID SERVICES | ř——— | | . 0938-039 |
|--------------------------|---|--|---------------------|--|---------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | l ` ' | | TE SURVEY MPLETED |
| | | 245388 | B. WING | 07 | /21/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| AKESH | ORE INN NURSING H | IOME | | 108 8TH STREET NORTHWEST WASECA, MN 56093 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIO DATE |
| K 000 | Continued From pa | age 2 | K 00 | 0 | |
| | | apacity of 55 beds and had a time of the survey. | | | |
| | NOT MET as evide | • | | | 04046 |
| K 025 SS=D | NFPA 101 LIFE SA | FETY CODE STANDARD | K 02 | 5 | 8/12/16 |
| | least a one half hou constructed in acco barriers shall be per atrium wall. Window fire-rated glazing of steel frames. 8.3, 19.3.7.3, 19.3. This STANDARD if Smoke barriers shall least a one half hou constructed in acco barriers shall be per atrium wall. Window fire-rated glazing of steel frames. 8.3, 19.3.7.3, 19.3. On facility tour betw on July 21, 2016, of penetration around | is not met as evidenced by: nall be constructed to provide at ur fire resistance rating and ordance with 8.3. Smoke ermitted to terminate at an ws shall be protected by r by wired glass panels and 7.5 ween 09:00 AM and 01:00 PM observation revealed that a I a 2" fire sprinkler pipe was | | Smoke barriers have been cemented in to reconstruct the smoke barrier. Walls should now be impermeable for at least 30 minutes. Director of Maintenance will monitor for future penetrations. | |
| K 038 SS=D | wing. NFPA 101 LIFE SA Exit access is arra | Noke barrier doors in the east NFETY CODE STANDARD Inged so that exits are readily | K 03 | 8 | 8/22/16 |
| | 7.1. 19.2.1 This STANDARD Exit access is arra | nes in accordance with section is not met as evidenced by: anged so that exits are readily nes in accordance with section | | We have ordered a panic bar for the exi door in the dining room. The hardware w be installed next week. | |

Event ID: BU2K21

Facility ID: 00682

If continuation sheet Page 3 of 6

| | | AND HUMAN SERVICES | | | FORM OMB NO. | APPROVE 0938-039 |
|--------------------------|--|--|--------------------|-----|---|---------------------------|
| ATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | CONSTRUCTION (X3) DATE | E SURVEY PLETED |
| | | 245388 | B. WING | | 07/: | 21/2016 |
| AME OF P | ROVIDER OR SUPPLIER | | | | | |
| AKESH | ORE INN NURSING H | IOME | | | 8 8TH STREET NORTHWEST ASECA, MN 56093 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETIC DATE |
| K 038 : | exit door in the dinr would not open and | age 3 bservation revealed that the ning room to outside area d has a door handle and dead Door is required to have panic | K |)38 | Director of Maintenance will arrange for the work to be done. | |
| K 056 SS=E | Where required by facilities shall be pr approved, supervis in accordance with systems are equipp switches which are the building fire ala construction, altern shall be permitted to protection in specif regulations prohibit NPFA 13 This STANDARD Where required by facilities shall be pr approved, supervis in accordance with systems are equipp switches which are the building fire ala construction, altern shall be permitted protection in specif regulations prohibit NPFA 13 On facility tour betto on July21, 2016, of is no fire protection | ative protection measures to be substituted for sprinkler ic areas where State or local t sprinklers. 19.3.5, 19.3.5.1, is not met as evidenced by: y section 19.1.6, Health care rotected throughout by an sed automatic sprinkler system section 9.7. Required sprinkler ped with water flow and tamper e electrically interconnected to | K | 056 | An extension of the current sprinkler system will be installed in the "link" at the end of the West Wing, fully sprinkling the building up to the smoke compartment door in the link. The bid has been signed and we are waiting on Olympic Fire to schedule the work. We are at their mercy with when the work can be completed but have notified them that we need it done as soon as possible. Director of Maintenance will arrange with Olympic the timing of the work being done. | 9/13/16 |
| | | | | | | |

Facility ID: 00682

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | | FORM | APPROVED 0938-0391 |
|--------------------------|--|--|---------------------------------------|-----|---|------------|----------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · | | E CONSTRUCTION 01 - MAIN BUILDING 01 | (X3) DATE | |
| | | 245388 | B. WING | | | 07/2 | 1/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | | · · · · · · · · · · · · · · · · · · · | | TREET ADDRESS, CITY, STATE, ZIP CODE | | |
| LAKESH | ORE INN NURSING H | OME | | | 08 8TH STREET NORTHWEST /ASECA, MN 56093 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| K 062 SS=D | continuously mainta condition and are in periodically. 19.7 9.7.5 This STANDARD i Required automati continuously mainta condition and are in periodically. 19.7 9.7.5 On facility tour betw on July 21, 2016, o | e sprinkler systems are ained in reliable operating spected and tested .6, 4.6.12, NFPA 13, NFPA 25, s not met as evidenced by: c sprinkler systems are ained in reliable operating spected and tested .6, 4.6.12, NFPA 13, NFPA 25, ween 09:00 AM and 01:00 PM bservation revealed that there found around new equipment | κo | 062 | The ceiling tile in the therapy room been replaced. Director of Maintenance will monito building for any missing tiles and re as he finds problems. | or the | |
| K 072 SS=D | Means of egress s | FETY CODE STANDARD hall be continuously maintained ons or impediments to full | | 072 | | | 8/12/16 |
| FORM CMS-2 | 567(02-99) Previous Version | s Obsolete Event ID: BU2K2 | 21 | Fa | cility ID: 00682 If contin | uation she | et Page 5 of 6 |

PRINTED: 08/15/2016

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | 08/15/2016 APPROVED 0938-0391 |
|--------------------------|---|---|---------------------|--|---|-------------------------------------|
| STATEMENT | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | TIPLE CONSTRUCTION NG 01 - MAIN BUILDING 01 | | E SURVEY PLETED |
| | | 245388 | B, WING | | 07/2 | 21/2016 |
| NAME OF F | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STAT | E, ZIP CODE | |
| LAKESH | ORE INN NURSING H | OME | | 108 8TH STREET NORTHW WASECA, MN 56093 | EST | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | ((EACH CORRECTIVE CROSS-REFERENCED | I OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY) | (X5) COMPLETION DATE |
| K 072 | No furnishings, dec obstruct exits, acce or visibility thereof s 7.1.10. 18.2.1, 19.2 This STANDARD is Means of egress s maintained free of a impediments to full or other emergency or other objects sha thereto, egress the shall be in accordan On facility tour betw on July 21, 2016, o | ase of fire or other emergency. corations, or other objects shall ess thereto, egress there from, shall be in accordance with 1 s not met as evidenced by: hall be continuously | κo | All items have been exit hallway. Items wi there. Director of Maintenar check the hallway to | ill no longer be stored , | |
| FORM CMS-25 | 67(02-99) Previous Versions | Obsolete Event ID: BU2K2 | 1 21 | Facility ID: 00682 | If continuation she | et Page 6 of 6 |



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 4, 2016

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5388027

Dear Mr. Corchran:

The above facility was surveyed on July 18, 2016 through July 21, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

Lakeshore Inn Nursing Home August 4, 2016 Page 2

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Kathryn Serie (507) 476-4233 or email: kathryn.serie@state.mn.us**.

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

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

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

Sincerely,

Mark meath

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

| Minnesc | ta Department of He | alth | | | | |
|--------------------------|--|---|---------------------|--|-------------------|--------------------------|
| - | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | E CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 00682 | B. WING | | 07/2 | 21/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| LAKESH | ORE INN NURSING H | OME | STREET NO | RTHWEST | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 000 | Initial Comments | | 2 000 | | | |
| | *****ATTE | NTION***** | | | | |
| | NH LICENSING | CORRECTION ORDER | | | | |
| | 144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall | Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health. | | | | |
| | corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess | hether a violation has been compliance with all rule provided at the tag ale number indicated below. Ins several items, failure to the items will be considered Lack of compliance upon ny item of multi-part rule will ment of a fine even if the item uring the initial inspection was | | | | |
| | that may result fron orders provided tha the Department wit | hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a ant for non-compliance. | | | | |
| | receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s obul.htm The Stat delineated on the a | participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are | | | | |
| ABORATOR | epartment of Health Y DIRECTOR'S OR PROVIE ically Signed | ER/SUPPLIER REPRESENTATIVE'S SIGI | NATURE | TITLE | | (X6) DATE 08/12/16 |

STATE FORM

If continuation sheet 1 of 29

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | | 00682 | B. WING | | 07/ | 21/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| AKESH | ORE INN NURSING H | IOME | I STREET NOR A, MN 56093 | THWEST | | |
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| 2 000 | Continued From pa | age 1 | 2 000 | | | |
| | you electronically. is necessary for Sta enter the word "cor text. You must ther State licensure pro completion date, th | Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for in indicate in the electronic cess, under the heading be date your orders will be electronically submitting to the nent of Health. | | | | |
| | surveyors of this D above provider and orders are issued. electronic plan of c | , 20th and 21st 2016, epartment's staff, visited the I the following correction Please indicate in your orrection that you have lers, and identify the date when tted. | n | | | |
| | the State Licensing federal software. Ta | nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for | | | | |
| | column entitled "IE statute/rule out of c "Summary Stateme and replaces the "T correction order. The findings which are after the statement evidence by." Follo | number appears in the far left O Prefix Tag." The state compliance is listed in the ent of Deficiencies" column Fo Comply" portion of the his column also includes the in violation of the state statute c, "This Rule is not met as wing the surveyors findings Method of Correction and rrection. | | | | |
| | FOURTH COLUM | ARD THE HEADING OF THE N WHICH STATES, N OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED 07/21/2016 | |
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| | | 00682 | B. WING | | | |
| AME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, | STATE, ZIP CODE | | |
| AKESH | ORE INN NURSING H | IOME | I STREET NO A, MN 56093 | RTHWEST | | |
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| | THIS WILL APPEA | R ON EACH PAGE. | | | | |
| | PLAN OF CORRE | QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF TE STATUTES/RULES. | | | | |
| 2 565 | MN Rule 4658.040 Plan of Care; Use | 5 Subp. 3 Comprehensive | 2 565 | | | 8/25/16 |
| | | omprehensive plan of care Il personnel involved in the t. | | | | |
| | by: Based on observat review the facility f developed to main motion (ROM) for reviewed for range Findings include: R33 was admitted progressive suprar which affects move | ent is not met as evidenced ion, interview and document ailed to follow the plan of care tain mobility and range of 2 of 3 residents (R33, R2) of motion. with diagnoses which included nuclear palsy (brain disorder ement), Parkinsonism, etes, anxiety and depression. | 1 | Corrected. | | |
| | program, but it was record and flow sh document the ROM Review of the med received physical t date of 1/13/16, an The daily treatmen | plan did not identify the ROM s identified on the treatment eet utilized by NAs to A activities. ical record indicated R33 herapy (PT) with a start of care d end of care date of 3/2/16. t note dated 3/2/16, stated has plateaued. Patients | | | | |

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | | E SURVEY PLETED |
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| NAME OF | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, S | TATE, ZIP CODE | • • • • | |
| LAKESH | ORE INN NURSING H | | I STREET NOF A, MN 56093 | RTHWEST | | |
| (X4) ID | SUMMARY STA | | | PROVIDER'S PLAN OF | CORRECTION | (X5) |
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| 2 565 | Continued From pa | age 3 | 2 565 | | | |
| | physical therapy as has been instructed continue under sup this time patient co dependent on all ca discomfort in the rig to a mild level. Pati discontinued (by P' with a maintenance under their supervi The PT discharges identified: Patient/ staff instructed in A plans and instruction resident of this exter receive a restorative Individualized exert detailed an exerciss note was provided individualized progr program a handwri identified PROM Bl and Evening. The i 5 repetitions of eact with each session. During observation provided bedtime (move her left hand elbow bent position right arm was stiff a Following the provi dressing in night cl from the toilet utiliz positioned on the s position remained s her chest, and ank toes pointed. Both was lying on her ba | program reviewed with sistant (PTA). Nursing staff d in ROM. This program will pervision of nursing staff. At ntinues to remain completely ares. Patient reports that ght upper arm has decreased ent's treatment supervision T). Nursing staff to continue e range of motion program sion." summary dated 3/2/16, Caregiver Training: Nursing ROM exercises. Discharge ons: Patient will remain a ended care facility and will re nursing program for ROM. cise program dated 12/14/15, e program to be provided. A for direct care staff with the ram identified. Following the tten note dated 2/25/16, UE and BLEs BID, Morning ndividualized program directed on 7/19/16, at 6:03 p.m. NA-E HS) care for R33. R33 did noi or arm and it remained in an h, held against her body. R33's and resistant to movement. sion of personal cares and othes, R33 was transferred ing the stand up lift and was ide of the bed. R33's body stiff with head forward toward les pronated downward and NAs positioned R33 so she ack in the bed. Once yed R33 was noted to have a | 3 t | | | |

| | D PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | | |
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| | ied From pa loth in her le | age 4 eft hand. The fingers of both | 2 565 | | | | | |
| made t or unde pillow u alright i verbaliz the upp perform limb. P- R33's o usual r stated f License on 7/20 rigid an R33 wa extrem On 7/20 and sta by staff arm an NA-A ir her low that wa body. Review R33 reu nothing provide Reques and res provide | b remove clear fingers. Ai inder R33's to provide ex- zed agreeme eer right arm- ning a total of ositioned res- cares were of outine for pe- herapy did t d practical i //16, at 7:55 d needed fu- ts supposed ties twice a D/16, at 1:11 ted R33 wa and a pillow d a roll was idicted R33 er body but s supposed of the NA fl beived ROM was docum d in the AM. st was made torative pro d. an orders si dmitted to the | rled position. No attempt wa oth and/or wash R33's palm t 6:34 p.m. NA-B positioned left arm, and asked if it was xercise at this time. R33 ent and NA-B provided ROM and both lower legs of three (3) repetitions for ea- sident for comfort, NA-B sta complete and this was the ersonal cares and ROM. NA the ROM on R33's right arm nurse (LPN)-A was interview a.m. and stated R33 was w III assist. LPN-A further state to receive ROM to all day morning and evening. 7 p.m. NA-A was interviewe s positioned in her bed or cl was placed under her left placed into her left hand. received ROM exercises to was not aware of any ROM to be provided for the uppe low sheet for 7/16 indicated 1 exercise in the PM but nented as having been e for a policy addressing RO grams, but nothing was | a a s A to ach ted -B ved very ed d hair r | | | | | |

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| 2 565 | Continued From pa | age 5 | 2 565 | | | |
| | 4/26/16, identified impairment, extens activities of daily liv limitation of upper a admission Care Ard 10/27/15, identified CVA (cerebral vaso hemiplegia. Staff p assistance with all transferred with a r (physical therapy) a to increase strengt | - | | | | |
| | sheet identified R2 motion) everyday a note dated 3/30/16 patient from formal week. A PROM (pa program was to co (RLE) and right upp | ent nursing assistant care as receiving ROM (range of as tolerated, slow/gentle. A PT , indicated plan to discharge I physical therapy by end of this assive range of motion) ntinue for right lower extremity per extremity (RUE) as well as ogram for maintenance. | 3 | | | |
| | 10/15/15, to 12/7/1 Progress & Discha identified that nursi | T (physical therapy) from 5. Review of the PT Therapis rge Summary dated 12/7/15, ing staff was instructed in a e of motion program. | t | | | |
| | up in wheelchair. R hand. R2 stated it h splint or palm prote | 5 a.m. R2 was observed sitting R2 was unable to open his right hurt if he tried to open it. No ector was in place. Nursing ot R2 up for the day and stated exercises with R2. | | | | |
| | | 08 a.m. COTA-B stated OT ked with R2 with ROM to the | | | | |

| TATEMENT OF DE ND PLAN OF COR | | (X1) PROVIDER/SUPPLIER/CLI. IDENTIFICATION NUMBER | | E CONSTRUCTION | | E SURVEY PLETED | |
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| affect He sta time a discol R2 fo not ha deem physic On 7/ open NA-B one ti happe On 7/ assist maint right s that P talkec with F stated On 7/ done for hin On 7/ (RN)- as ide NA's | ated R2's har and R2 had re- training re-t | e if ROM could be improven nd was not contracted at the eached a plateau so OT we also stated OT did not look gram. He stated the facility tive program so if nursing riate they could get a and evaluate R2 for PT or 0 10 a.m. NA-B stated, "he courts too much." Additionally did not do exercises on R2 brace but I don't know whe stated R2 was on a ram for ROM mainly for the nt contractures. She indicate a program for nursing and take sure they were continu- ent contractures. She also Id be doing it daily." 5 a.m. NA-C stated she have as for R2. "We don't do R0 | at as at did DT. an't "At at e ted uing dd DM the daily e ated | DEFICIENC | ;γ) | | |

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| 2 565 | Continued From pa | age 7 | 2 565 | | | |
| | nurse should be no | tified. | | | | |
| | A policy on ROM w provided by the fac | as requested but none was ility. | | | | |
| | director of nursing review and revise p to ensuring the car resident is followed develop a system t monitoring system | THOD OF CORRECTION: Th (DON) or designee could policies and procedures relate e plan for each individual I. The DON or designee could o educate staff and develop a to ensure staff are providing the written plan of care. | b | | | |
| | TIME PERIOD FOI (21) days. | R CORRECTION: Twenty-one |) | | | |
| 2 830 | MN Rule 4658.052 Proper Nursing Ca | 0 Subp. 1 Adequate and re; General | 2 830 | | | 8/22/16 |
| | receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as written order from t | general. A resident must re and treatment, personal and supervision based on ad preferences as identified in resident assessment and scribed in parts 4658.0400 an ing home resident must be ou possible unless there is a he attending physician that th ain in bed or the resident n bed. | d | | | |
| | by: Based on observat | ent is not met as evidenced ion, interview and document ailed to assess pain and | | Corrected. | | |

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| 2 830 | Continued From pa | age 8 pain control for 1 of 1 residents | 2 830 | | | | |
| | (R2) reviewed for p R2 as he experience on a daily basis that untreated. Therapy | bain. This resulted in harm for ced moderate to severe pain at remained unassessed and r notes identify R2 had ng back to date of admission. | | | | | |
| | Findings include: | | | | | | |
| | was admitted to the diagnosis including (CVA) with hemiple | igned 7/19/16, identified R2 e facility on 10/14/15, with g a cerebral vascular accident egia (paralysis) affecting right e aphasia (loss of the ability to | | | | | |
| | 4/26/16, identified impairment, extens activities of daily liv limitation of upper admission Care Ar 10/27/15, identified CVA with right hem extensive to total a did not walk, transf and received PT (p | num Data Set (MDS) dated moderate cognitive sive assistance needed with all ving (ADL's) and a functional and lower extremities. The ea Assessment (CAA) dated d R2 as having a history of a hiplegia. Staff provide sssistance with all ADL's. R2 ferred with a mechanical lift physical therapy) and OT apy) to increase strength and | | | | | |
| | was observed to gr arm/hand was touc it. P2 was observe with his left hand a | n on 7/19/16, at 6:00 p.m. P2 rimace any time the right ched or he attempted to move ed to lift his right hand/arm up nd stated "Ouch!" When modded his head yes. | | | | | |
| | up in the wheelcha | 5 a.m. R2 was observed sitting ir. R2 was unable to open his ed it hurt if he tried to open it. | | | | | |

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| 2 830 | Continued From pa | age 9 | 2 830 | | | |
| | sitting up in the who clenched. When a he shook his head | 0 a.m. R2 was observed eelchair. R2 had his right hand sked if he could open his hand no and indicated it hurt if he n was lightly touched, R2 | | | | |
| | therapist registered the dining room. W right arm/hand, he stated "ouch!" OTH R2 in occupational | 47 p.m. OTRL (occupational I licensed)-A observed R2 in 'hen OTRL-A touched R2's grimaced with pain and loudly RL stated she had worked with therapy (OT) in the fall and 2's right side was very | | | | |
| | in the dining room v attempted to lift his hand. R2 was obse if it hurt, he nodded | 9 p.m. R2 was observed sitting with his wife. His wife right arm/hand to look at his erved to grimace. When asked his head yes. R2's wife lly seem to hurt him." | | | | |
| | in the dining room. arm/hand, he shrug unable to open his | 2 a.m. R2 was again observed When asked about his right gged his shoulders. R2 was hand and when he attempted grimaced and expressed pain. | | | | |
| | (NA)-E and NA-F w (mechanical lift dev NA-F attempted to the EZ lift R2 cried NA-F asked R2 wh | 09 a.m. nursing assistant vere observed using the EZ lift vice) to lay R2 in bed. When lift his right arm to hold onto out, "No! No! Ouch! Ouch!" at his pain level was and R2 ale of 0-10 with 10 being the | | | | |
| | Review of the med | ical record identified R2 had | | | | |

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| 2 830 | Continued From pa | ige 10 | 2 830 | | | |
| | included: 10/29/16 - [R2] was splint on therapist a significant pain and (passive range of n extremity). 11/3/15 - [R2] care and daughters. Ma including RUE pain 11/9/15 - PROM ve pain and refusing. 11/16/15 - [R2] had and forearm today. 11/20/15 - [R2] corr 11/23/15 - PROM F complaints of pain. 11/25/15 - did not v with movement with 11/26/15 - PROM w pain, OT only able 11/27/15 - [R2] has caused pain in RUE 12/2/15 - Limited P due to pain. 12/8/15 - noted righ tolerated gentle PR 12/8/15 - Therapist Summary dated ider right hand to several hand to mild on 11/ mild but demonstrative verbalizations durin moderate on 12/8/17 Review of the medii (MAR) from April 20 had an order for Ty every 4 hours as ne | ry limited due to [R2] reporting significant pain in right hand aplained of discomfort at times RUE with limited ROM and erbalize pain but grimaced a PROM. with maximum complaints of to do minimal ROM. stiff digits and extension E. ROM as [R2] would not allow at hand joint contracture, [R2] OM. Progress & Discharge entified [R2] reports pain in e on 10/29/15, pain in right 25/15 and pain in right hand to ted facial grimaces and ag ROM to indicate pain is | | | | |

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| 2 830 | 2016, 6 times in Ju 2016. Review of th 12 times the PRN given 3 times for an times for pain. Nun 5/24/16, R2 complai identified a pain lev being worst pain). Complaints of pain 5/29/16, R2 had ex pain level of 5. On "all over" and a pai again complained of pain at a level 5. O pain "all over" and 6/6/16, R2 complai his pain level as 6. over" and rated his R2 had pain "all ove 5. | ril of 2016, 5 times in May ine 2016, and none in July ne nurses' notes clarified of the Tylenol was given, it had been n elevated temperature and 9 rsing notes identified on ained of pain "all over" and had vel of 5 of 10 (0 not pain, 10 On 5/26/16, R2 had "vocal (that hurts, ouch, stop). On cpressed pain "all over" and a 6/1/16, R2 complained of pain n level of 4. On 6/2/16, R2 of pain "all over" and rated the n 6/3/16, R2 complained of rated the pain level as 5. On ned of pain "all over" and rated On 6/11/16, R2 had pain "all pain level as 4. On 6/12/16, er" and rated the pain level as | 1 | | | | |
| | identified the facility identifying the inter (5 as the highest a was the facility poli utilize this scale as pain greater than 5 with the PRN Tyler was used or the lev administration of Ty assessment, there acceptable level of was unclear what F movement, at rest, movement. | nent Policy revised 8/03, y pain protocol included nsity of pain using a 0-5 scale mount of pain). Although this cy, staff did not consistently evidenced by R2 rating his to there was no documentation not to identify what pain scale vel of relief obtained with the ylenol. Further, without a pain was no evidence of what an pain was for R2. In addition, it R2's level of pain was with and at rest following | | | | | |
| | | d 10/26/15, identified impaired ory of cerebral vascular | | | | | |

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| AKESH | ORE INN NURSING I | HOME | H STREET NOR CA, MN 56093 | THWEST | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC | FION SHOULD BE THE APPROPRIATE | (X5) COMPLE DATE |
| 2 830 | Continued From pa | age 12 | 2 830 | | | |
| | approach of "assur management." The identified. Without for pain, there were management appr On 7/20/16, at 11:1 open his hand it hu On 7/21/16, at 9:15 morning cares for ROM for him as it if really complained of right side. NA-C sta pain is more than u was aware that it b On 7/21/16, at 10:0 "sometimes I try to | ere were no interventions a comprehensive assessmen e no individualized pain oaches identified for R2. 10 a.m. NA-B stated, "he can't | t | | | |
| | (LPN)-A stated the stated he had pain |) a.m. licensed practical nurse aides had not reported R2 . She stated "I think he just e touching that arm." | e | | | |
| | (RN)-B verified a p been completed or | 00 a.m. registered nurse ain assessment should have n R2 and staff should have reased pain to nurse. | | | | |
| | identified it was fac amount of pain a re to evaluate the ana pain protocol inclue pain using a 0-5 sc | nent Policy revised 8/03, cility policy to assess the esident was experiencing and algesic prescribed. The facility ded identifying the intensity of cale (5 as the highest amount used, plan and comments an | | | | |

| Minnesc | ta Department of He | alth | - | | | |
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| - | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | (X3) DATE COMP | SURVEY LETED |
| | | 00682 | B. WING | | 07/2 | 1/2016 |
| NAME OF I | PROVIDER OR SUPPLIER | STREET AD | DRESS, CITY, S | STATE, ZIP CODE | | |
| LAKESH | ORE INN NURSING H | IOME | STREET NO , MN 56093 | RTHWEST | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY) | D BE | (X5) COMPLETE DATE |
| 2 830 | Continued From pa | ge 13 | 2 830 | | | |
| | also indicated an or would be addressed SUGGESTED MET The director of nursi develop systems to their pain managen designee could edu the collaboration of could develop a mo ongoing compliance the quality assurance | al interventions. The policy ngoing pain management plan d on the resident's care plan. THOD OF CORRECTION: sing (DON) or designee could ensure that all residents have nent needs met. The DON or licate all appropriate staff on pain. The DON or designee ponitoring systems to ensure e and present those findings to | | | | |
| | (21) days. | , | | | | |
| 2 895 | MN Rule 4658.052 Motion | 5 Subp. 2.B Rehab - Range of | 2 895 | | | 8/25/16 |
| | that is directed towa through positioning implemented and n comprehensive res of nursing services development of a n provides that: | motion. A supportive program ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which h a limited range of motion | | | | |
| | receives appropriat increase range of n decrease in range of | e treatment and services to notion and to prevent further of motion. | | | | |
| | by: | ent is not met as evidenced on, interview and document | | Corrected. | | |
| Minnesota D | epartment of Health | | μ | | | 1 |

| | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| AME OF | PROVIDER OR SUPPLIER | | DRESS, CITY, ST | TATE, ZIP CODE | | |
| AKESH | ORE INN NURSING H | | STREET NOR | THWEST | | |
| (X4) ID | SUMMARY ST | | , MN 56093 | PROVIDER'S PLAN OF | COBRECTION | (X5) |
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| 2 895 | Continued From pa | age 14 | 2 895 | | | |
| | motion (ROM) serv mobility for 2 of 3 re for range of motion Findings include: R33 was admitted of progressive supran which affects move osteoporosis, diable Review of the medi received physical the date of 1/13/16, an The daily treatment "Patient progress has restorative nursing physical therapy as has been instructed continue under sup this time patient co dependent on all ca discomfort in the rig to a mild level. Pati discontinued (by P with a maintenance under their supervis PT daily treatment 2/16/16: received p (PROM) with end s extremities(BUE) a (BLE) to improve R positioning and cor 2/18/16: Resident Tolerated PROM to range stretch to all 10 repetitions. Actia at fingers, wrist, elk repetitions. Tolerat current plan of care decrease pain. | with diagnoses which included nuclear palsy (brain disorder ement), Parkinsonism, etes, anxiety and depression. ical record indicated R33 herapy (PT) with a start of care d end of care date of 3/2/16. t note dated 3/2/16, stated as plateaued. Patients program reviewed with sistant (PTA). Nursing staff d in ROM. This program will pervision of nursing staff. At ntinues to remain completely ares. Patient reports that ght upper arm has decreased ent's treatment supervision T). Nursing staff to continue e range of motion program sion." notes identified: hassive range of motion tretch bilateral upper nd bilateral lower extremities COM for wheelchair (W/C) | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED |
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| 2 895 | Continued From pa | ige 15 | 2 895 | | | |
| | Instructed nursing a and AROM program discharge patient to on a PROM program 2/25/16: Instructed identified), in PROM once in the a.m. be once in p.m. before night nurse regardi The PT discharge as identified: Patient/0 staff instructed in A plans and instruction resident of this exter receive a restorative Individualized exerce detailed an exerciss note was provided individualized program a handwri identified PROM Bl and Evening. The i 5 repetitions of eact with each session. During observation provided bedtime (not observed to ass transfer from chair was utilized. R33 d arm and it remaine held against her bo and assisted with w and NA-C assisted body. R33's right at movement. Followi cares and dressing transferred from the | I 3 NA staff (individuals not I to be done twice a day (BID) efore getting out of bed and e going to bed Spoke with ng program follow up. summary dated 3/2/16, Caregiver Training: Nursing ROM exercises. Discharge ons: Patient will remain a ended care facility and will e nursing program for ROM. cise program to be provided. A for direct care staff with the 'am identified. Following the tten note dated 2/25/16, JE and BLEs BID, Morning ndividualized program directed h exercise to be completed on 7/19/16, at 6:03 p.m. NA-B HS) care for R33. R33 was sist with position changes or to toilet or bed and a stand lift id not move her left hand or d in an elbow bent position, dy. NA-C came into the room /ashing resident. Both NA-B I with dressing R33's upper rm was stiff and resistant to ng the provision of personal in night clothes, R33 was e toilet utilizing the stand up lift I on the side of the bed. R33's | | | | |

| | ta Department of He IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| | PROVIDER OR SUPPLIER | | DDRESS, CITY, ST | | 07/ | 21/2016 |
| | | 108 8TH | STREET NOR | | | |
| AKESH | ORE INN NURSING H | WASEC/ | A, MN 56093 | | | |
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| | and toes pointed. E she was lying on he positioned on the b rolled cloth in her le hands were in a cu made to remove clio or under fingers. Ai pillow under R33's alright to provide ex- verbalized agreeme upper right arm and total of three (3) rep Positioned resident R33's cares were co usual routine for per- stated therapy did to Licensed practical on 7/20/16, at 7:55 total assistance wit (ADLs) and that sh full assist. LPN-A for supposed to receive a day morning and reported the declined discussed at the m 7/18/16. It was als tear on the posterio this was thought to and R33's inability On 7/20/16, at 1:1' and stated R33 wa by staff and a pillow arm and a roll was NA-A indicted R33 her lower body but | and ankles pronated downward Both NAs positioned R33 so er back in the bed. Once bed R33 was noted to have a eft hand. The fingers of both inled position. No attempt was oth and/or wash R33's palms t 6:34 p.m. NA-B positioned a left arm, and asked if it was xercise at this time. R33 ent and NA-B provided ROM to d both lower legs performing a petitions for each limb. t for comfort, NA-B stated complete and this was the ersonal cares and ROM. NA-B the ROM on R33's right arm. nurse (LPN)-A was interviewed a.m. and stated R33 required th activities of daily living e was very rigid and needed urther stated R33 was re ROM to all extremities twice evening. In addition LPN-A e in ADL status had been ost recent care conference on o indicated R33 had a skin or surface of her left hand and be the result of using the lift to grip with her left hand. 7 p.m. NA-A was interviewed s positioned in her bed or chai was placed under her left placed into her left hand. received ROM exercises to was not aware of any ROM to be provided for the upper | | | | |

| TATEMEN | ta Department of H IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | · · / | CONSTRUCTION | | E SURVEY PLETED |
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| 2 895 | Continued From pa | age 17 | 2 895 | | | |
| | nothing was docum provided in the AM Review of the care program, but it was record and flow sh document the ROM Request was made | e plan did not identify the ROM s identified on the treatment eet utilized by NAs to | | | | |
| | was admitted to th diagnoses includin | igned 7/19/16, identified R2 e facility on 10/14/15, with g a cerebral vascular accident egia (paralysis) affecting the | | | | |
| | 4/26/16, identified impairment, extens activities of daily liv limitation of upper admission Care Ar 10/27/15, identifie CVA (cerebral vaso hemiplegia. Staff p assistance with all transferred with a | mum Data Set (MDS) dated moderate cognitive sive assistance needed with al ving (ADL's) and a functional and lower extremities. The ea Assessment (CAA) dated d R2 as having a history of a cular accident) with right provided extensive to total ADL's. R2 did not walk, mechanical lift and received P ⁻ and OT (occupational therapy) th and mobility. | Г | | | |
| | sheet identified R2 motion) everyday a note dated 3/30/16 patient from forma week. A PROM (p program was to co (RLE) and right up | ent nursing assistant care was receiving ROM (range of as tolerated, slow/gentle. A PT indicated a plan to discharge l physical therapy by end of thi assive range of motion) intinue for right lower extremity per extremity (RUE) as well as ogram for maintenance. | s | | | |

| STATEMEN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| (X4) ID | SUMMARY STA | | | PROVIDER'S PLAN OF C | ORRECTION | (X5) |
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| 2 895 | Continued From pa | age 18 | 2 895 | | | |
| | 10/15/15, to 12/8/1 identified : 10/26/15, mild to m in hand. A trial of a initiated to maintair further contracture. 10/29/15, pt was n and significant com noted in the RUE. splint R2 had from the splint did not ac temporary resting s hand. 11/2/15, a new rest The splint that was placed temporarily 11/3/15, a care con time "many concert OT interventions re pain management. 11/4/15, a splint wa arm/hand. 11/10/15, it was not allow for hygiene at RUE. 11/12/15, a new rig Photos were taken wearing schedule w (certified occupatio who would monitor 11/16/15, the right f difficulty. Splint wa 11/22/15 to 11/30/1 placement was not 11/30/15, PROM w | ot wearing right resting splint tracture/limited prom was Pt's wife had brought in a a previous hospitalization but ddress finger contractures. A splint was placed on R2's right ing splint was ordered for R2. available at the facilty was on R2's right arm/hand. ference was held at which ns were discussed, including garding splinting and RUE " is again applied to R2's ted R2 needed daily PROM to nd maintain skin integrity to ght resting splint was applied. for staff instruction and a vas discussed with the COTA nal therapy assistant) staff status later in the day. resting splint was applied and r 2 hours of wearing the splint. hand splint was applied without s noted to be on 11/22/15. 5, no mention of splint | | | | |

| AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED |
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| page 19 | 2 895 | | | |
| int but was unable to apply. protector was applied to right d the functional hand splint. is educated on the palm protect nt with the plan. a noted to be wearing the palm on a splint that therapy did not nt was not working and the CO ⁻ T - Therapist Progress & mary dated 12/8/15, identified a 5, of "Caregiver appropriately esting splint orthotic to monitor or effective skin and joint contracture management" This ied as being met on 12/8/15. d PT (physical therapy) from 7/15. Review of the PT Therap charge Summary dated 12/7/15, ursing staff was instructed in a nge of motion program. 7:15 a.m. R2 was observed sittir r. R2 was unable to open his rig it hurt if he tried to open his rig it hurt if he tried to open his rig Agot R2 up for the day and state to exercises with R2. 0:08 a.m. COTA-B stated OT vorked with R2 with ROM to the see if ROM could be improved. hand was not contracted at that | cor TA pist pist ed | | | |
| | IDENTIFICATION NUMBER: 00682 JER STREET IG HOME 108 8' WASE STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) IDENTIFYING INFORMATION) In page 19 Iong. OT attempted to don right int but was unable to apply. In protector was applied to right ad the functional hand splint. IDENTIFYING INFORMATION) In page 19 Ion a splint that therapy did not int was not working and the CO In T - Therapist Progress & mary dated 12/8/15, identified a 5, of "Caregiver appropriately esting splint orthotic to monitor or effective skin and joint contracture management" This ied as being met on 12/8/15. In PT (physical therapy) from 7/15. Review of the PT Therap charge Summary dated 12/7/15, ursing staff was instructed in a nge of motion program. 7:15 a.m. R2 was observed sittir r. R2 was unable to open his rig d it hurt if he tried to open it. No rotector was in place. Nursing Agot R2 up for the day and state ny exercises with R2. 10:08 a.m. COTA-B stated OT worked with R2 with ROM to the see if ROM could be improved. hand was not contracted at that d reached a plateau so OT was e also stated OT did not look at | IDENTIFICATION NUMBER: A. BUILDING: 00682 B. WING | IDENTIFICATION NUMBER: A. BUILDING: 00682 B. WING IER STREET ADDRESS, CITY, STATE, ZIP CODE IG HOME 108 8TH STREET NORTHWEST WASECA, MN 56093 STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL ID PREFIX TAG OR LSC IDENTIFYING INFORMATION) PREFIX TAG In page 19 2 895 Iong, OT attempted to don right int but was unable to apply. PREFIX In page 19 2 895 Ion a splint that therapy did not int was not working and the COTA In page 12/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/ | IDENTIFICATION NUMBER: A. BUILDING: 00062 07/ JUR STREET ADDRESS, CITY, STATE, ZIP CODE 108 8TH STREET NORTHWEST 07/ IGHOME 108 8TH STREET NORTHWEST WASECA, NM 56093 000000000000000000000000000000000000 |

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| 2 895 | Continued From pa | age 20 | 2 895 | | | |
| | deemed it appropri | ive program so if nursing ate they could get a nd evaluate R2 for PT or OT | | | | |
| | open his hand it hu NA-B state staff die | 0 a.m. NA-B stated, "he can Irts too much." Additionally d not do exercises on R2 "At brace but I don't know what | | | | |
| | therapist registered with R2 for a splint stated it was passe splint schedule in 1 and stated his hand contracted) than it wife brought in a sp | 29 p.m. OTRL (occupational d licensed)-A stated OT work for the right arm/hand. She ed on to nursing to set up the 2/15. OTRL-A observed R2 d was not any worse (more was before. She thought his plint but they tried a different member if it worked for R2 o | ed | | | |
| | assistant (PTA)-A s maintenance progr right side to prever that PT wrote up a talked to staff to ma | am for ROM mainly for the at contractures. She indicated program for nursing and ake sure they were continuin nt contractures. She also | | | | |
| | interviewed. She s for him at home an | 9 p.m. R2's wife was tated she never had a splint d had not brought one to the he thought that would be a | | | | |
| | | 5 a.m. NA-C stated she had s for R2. "We don't do ROM painful." | | | | |

| | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | CONSTRUCTION | | E SURVEY PLETED |
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| 2 895 | Continued From pa | ge 21 | 2 895 | | | |
| | | 8 a.m. NA-D stated, do a little ROM on him but he so I don't do it." |) | | | |
| | (RN)-A verified R2 as identified by the NA's learn ROM in they usually did it 5 NA flow sheet shou ROM was being do refusing or staff wa nurse should be no OT had recomment protector and stated communicated and | 0 a.m. registered nurse should be receiving ROM dai flow sheet. She stated the NA class. RN-A further stated -10 minutes. She stated the Id have identified where the ne. RN-A stated if R2 was s not completing the ROM th tified. She was unaware that ded the use of a palm d that should have been placed on the NA flow sheet as requested but none was ility. | e e | | | |
| | The director of nurs review range of mo residents receive a or designee could e staff/departments to assessed for ROM appropriate service designee, could con delivery of care to e services are implem | THOD OF CORRECTION: sing (DON) or designee, could tion systems to ensure all ppropriate services. The DON educate all appropriate to ensure all residents are needs and receive s. The director of nursing or induct random audits of the ensure appropriate care and nented. Results of the audits with the quality assurance | | | | |
| | TIME PERIOD FOR (21) days. | R CORRECTION: Twenty-on | e | | | |
| 21390 | MN Rule 4658.0800 | 0 Subp. 4 A-I Infection Contro | ol 21390 | | | 8/22/16 |

| T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED | |
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| ORE INN NURSING H | IOME | | RTHWEST | | | |
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| Subp. 4. Policies control program maprocedures which p A. surveillance collection to identify residents; B. a system fo control of outbreak C. isolation and reduce risk of trans D. in-service e prevention and con E. a resident h immunization progra defined in part 465 procedures of resid the prevention and F. the develop employee health pop practices, including defined in part 465 G. a system fo H. a system fo products which affed disinfectants, antisi incontinence produ I. methods for current standards of This MN Requirem by: Based on interview facility failed to ens | and procedures. The infection ust include policies and provide for the following: based on systematic data y nosocomial infections in r detection, investigation, and s of infectious diseases; d precautions systems to smission of infectious agents; ducation in infection atrol; ealth program including an ram, a tuberculosis program as 58.0810, and policies and dent care practices to assist in treatment of infections; ment and implementation of policies and infection control g a tuberculosis program as 8.0815; or reviewing antibiotic use; r review and evaluation of ect infection control, such as eptics, gloves, and nots; and maintaining awareness of of practice in infection control. ent is not met as evidenced and document review the sure Tuberculosis symptom | | Corrected. | ς Υ) | | |
| , | ROVIDER OR SUPPLIER DRE INN NURSING F SUMMARY ST/ (EACH DEFICIENC) REGULATORY OR L Continued From pa Subp. 4. Policies control program mu procedures which p A. surveillance collection to identify residents; B. a system fo control of outbreak C. isolation an reduce risk of trans D. in-service e prevention and cor E. a resident h immunization program defined in part 465 procedures of resident the prevention and F. the develop employee health por practices, including defined in part 465 G. a system for H. a system for products which affed disinfectants, antisis incontinence produ I. methods for current standards of This MN Requirem by: Based on interview facility failed to ens | TOF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DECORRECTION 00682 ROVIDER OR SUPPLIER STREET AU DRE INN NURSING HOME 108 8TH WASECA 108 8TH SUMMARY STATEMENT OF DEFICIENCIES [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 22 Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infectious agents; D. in-service education in infectious agents; D. in-service education in infectious agents; D. in-service education in infections; F. the development and implementation of employee health policies and infection control program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and In methods for maintaining awareness of current standards of practice | TOF DEFICIENCIES DE CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPI A. BUILDING O0682 B. WING ROVIDER OR SUPPLIER STREET ADDRESS, CITY, ORE INN NURSING HOME 108 8TH STREET NO WASECA, MN 56093 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 22 21390 Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies to assist in the prevention and treatment of infection; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure Tuberculosis symptom | TOF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DOG82 B. WING NOVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE TORE INN NURSING HOME 108 8TH STREET NORTHWEST WASECA, MN 56093 SUMMARY STATEMENT OF DEFICIENCY REQULATORY OR LSC IDENTIFYING INFORMATION) Image: Construction of the construction on the construction of the construction on the construction of the construction of the consthe constre construction of the construction on the cons | TOF DEFICIENCIES (X1) PROVIDERSUPPLIENCLA. (X2) MUITIFLE CONSTRUCTION (X3) DATA DEF CORRECTION 00682 B. WING 07/ ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 07/ SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX PROVIDERS PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX PREFIX PROVIDERS PLAN OF CORRECTION REQULATORY OR LSC IDENTIFYING INFORMATION PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX PREFIX CONSTRUCTION HUBBE CONSTRUCTION HUBBE CONSTRUCTION DI D | |

Minnesota Department of Health STATE FORM

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | . , | | | E SURVEY PLETED |
|--------------------------|--|---|---------------------------|---|-----------------------------------|-------------------------|
| | | 00682 | B. WING | | 07/21/2016 | |
| NAME OF I | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| AKESH | ORE INN NURSING H | | STREET NOR A, MN 56093 | THWEST | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC | TION SHOULD BE THE APPROPRIATE | (X5) COMPLET DATE |
| 21390 | | age 23 ed on 2/25/16 and received a 7/16 and 3/12/16. No symptom | 21390 | | | |
| | screening was com 2. R33 had an adm received a 2-step T No symptom scree 3. R44 had an adm received a 2-step T No symptom scree 4. R47 had an adm received a 2-step T No symptom scree 5. R48 was admitte TST on 8/15/15 and screening was com 6. R59 had an adm received the first of No symptom scree During interview wi (DON) on 7/20/16, Tuberculosis (TB) s being completed fo confirmed the only was the admission | npleted. nission date of 4/27/16 and ST on 4/29/15 and 5/13/15. ning was completed. nission date of 10/13/15 and ST on 10/22/15 and 11/5/15. ning was completed. ission date of 7/21/15 and ST on 7/23/15 and 8/6/15. ning was completed. ed on 8/12/15, received 2-step d 8/28/15. No symptom | | | | |
| | was interviewed on indicated she was i complete a TB sym admissions. Review | RN)-A (infection control nurse) 7/20/16, at 11:25 a.m She not aware of the need to aptom screening for new w of the admission history form the screening for signs and was not completed. | | | | |
| | Home and Boardin provided as part of | creening Tool for Nursing g Care Home Residents was the facility infection control N-A as well as the DON | | | | |

| | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | | E SURVEY PLETED | |
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| | | 00682 | B. WING | | 07/ | 07/21/2016 | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | | |
| AKESH | ORE INN NURSING H | IOME | I STREET NOR A, MN 56093 | THWEST | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE | |
| 21390 | Continued From pa | age 24 | 21390 | | | | |
| | verified it was not o admissions. | currently being utilized for | | | | | |
| | with a review date with a positive Mar if chest x-rays are TB infection, no fur resident with a pos symptoms of active suspicious for TB. be notified for furth | ulosis Policy and Procedures of 10/15 indicated residents atoux needed a chest x-ray x 1 negative with no symptoms of ther x-rays needed. Any itive PPD(TB test) and a TB will be considered A physician and the DON will er direction to transfer the y that is able to provide care. | ; | | | | |
| | The director of nur- ensure current tube management proto Centers for Diseas Minnesota Departm followed. The DON appropriate staff ar designee could dev ensure ongoing co | THOD OF CORRECTION: sing (DON) or designee could erculosis prevention and bools as directed by the e Control (CDC) and nent of Health (MDH) are l or designee could ensure all re educated. The DON or velop a monitoring system to mpliance. The DON or bort monitoring results to the committee. | | | | | |
| | TIME PERIOD FO (21) days. | R CORRECTION: Twenty-one | • | | | | |
| 21695 | MN Rule 4658.141 Housekeeping, Op | 5 Subp. 4 Plant eration, & Maintenance | 21695 | | | 9/5/16 | |
| | provide housekeep necessary to maint comfortable interio | eeping. A nursing home must bing and maintenance services cain a clean, orderly, and r, including walls, floors, fixtures, equipment, lighting, | ; | | | | |

If continuation sheet 25 of 29

| Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00682 | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | | |
|--|---|--|---|---|-------------------------------|------------------------|--|
| | | B. WING | 07/21/2016 | | | | |
| NAME OF F | PROVIDER OR SUPPLIER | STREET AI | B. WING C | | | 0172172010 | |
| AKESH | ORE INN NURSING H | | STREET NC | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE CC | (X5) DMPLET DATE | |
| 21695 | Continued From pa | age 25 | 21695 | | | | |
| | by: Based on observat review, the facility f | ent is not met as evidenced ion, interview, and document failed to maintain a clean, ent, and resident rooms in good residents. | I | Corrected. | | | |
| | Findings include: | | | | | | |
| | 7/18/16, and verifie | d during the initial tour on ed on 7/21/16, at 12:50 p.m. ental director (ED) were as | | | | | |
| | bulged outward alo was cracked open, wet, substance tha The paint and surfa moist and easily cr The opening was a and gapped 4 inche identified that she r 4/16, but no repairs in the room the ED damaged wall. 2. R57's bathroom The white tiles with were discolored. | wall was damaged, the wall ong the floor board. The wall and revealed a black, loose, t was visible inside the wall. ace around the opening was umbled away when touched. approximately 18 inches long es. Family member (FM)-A reported the damaged wall in s had been completed. While verified he was aware of the had a pungent foul urine odor a grout had black debris and | | | | | |
| | could be detected a 4. R14's bathroom smell which seems entryway to the roo noted to be heavily and surface damag 5. R1's bathroom h | at the entry door to the room. had a strong malodorous d to concentrate by the om. The bathroom door was scraped, with missing paint ge. had a strong urine odor. There | | | | | |
| nesota De | were 1 to 2 inch ho epartment of Health | les and gouges noted on the | | | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 00682 | | | 07/21/2016 | | |
| IAME OF | PROVIDER OR SUPPLIER | STREET A | DRESS, CITY, S | TATE, ZIP CODE | - | | |
| AKESH | IORE INN NURSING H | | STREET NOF | THWEST | | | |
| | | WASECA | , MN 56093 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLE DATE | |
| 21695 | Continued From page 26 | | 21695 | | | | |
| | sink. The door fram bathroom, were he chipped off. 6. R25's bathroom noted to be heavily revealed paint rem 7. R13's room reve were in need of rep were marked with H bathroom door fram marks and the surf damaged. 8. R45's wall on th a 2 inch gouge to t surface was heavil 9. R39's ceiling tile across the tile. 10. R41's wall beh covering an area 4 bubbled, and when which crumbled. Th moisture. 11. R38's walls rev severe scrapes, an stated that they hav moved in a year ag bathroom had a bu was stained, brown away when touched door frames, were were heavily scraped, bl paint was missing. surface damaged, revealing the sheet Plexiglass walls su | e was cracked completely ind her chair was damaged x 3 feet. The surface was touched was full of moisture, he paint was releasing from vealed holes, black marking, nd paint missing. The resident ve been there since she go. The corners of the hild up of debris, and the grout n and yellow and crumbled d. The bathroom and entry stained, had black marks, and ed with surface damage. et of the dining room walls were ack marks were evident, and Sections of wall paper were and releasing from the wall t rock underneath. The rrounding the coffee serving and the surface was scraped, | | | | | |

| Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00682 | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| | | 00682 | B. WING | | 07/ | 07/21/2016 |
| NAME OF F | PROVIDER OR SUPPLIER | STREET A | DDRESS, CITY, ST | TATE, ZIP CODE | | |
| AKESH | ORE INN NURSING H | IOME | STREET NOR A, MN 56093 | THWEST | | |
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| 21695 | Continued From pa | ige 27 | 21695 | | | |
| | a quarterly schedul environmental reparent However upon requ any such schedule. housekeeping staff bathroom daily. He existed, and turned fans during the tour housekeepers were repairs were neede ED presented a clip communication, whi issues in need of re- the communication Review of the polic Housekeeping Infe- included patient bar every six months we dated as revised 1/ Policy identified rou- to be performed da with input from othe repair sheets locate on the East Wing. S contact maintenand something needed semi-annual basis, housekeeping depa- room floors, mainter rooms to repair any The checklist include | cleaned each room and was unsure why the odors on three bathroom exhaust r. The ED stated the e responsible to report when ad. When in the west wing the board that was used for then there were environmental epair. There were no notes on board. y dated as revised 1/15, ction Control Guidelines throom wall tile was scrubbed ith disinfectant. The policy 14, titled Building Maintenance was ily by the maintenance staff, er departments utilizing the ed in the South Wing and one Staff nurses were instructed to ce staff immediately if to be repaired sooner. On a | | | | |
| | The administrator of | HOD OF CORRECTION: or designee could develop, se policies and procedures to | | | | |

| Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00682 | | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION A. BUILDING: | | (X3) DATE SURVEY COMPLETED | |
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| | | B. WING | | 07/21/2016 | | |
| | | | DDRESS, CITY, ST | | | |
| | IORE INN NURSING H | 108 8TH | I STREET NOR | | | |
| | I | WASEC | A, MN 56093 | | | |
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| 21695 | Continued From page 28 | | 21695 | | | |
| | The administrator of appropriate staff or for reporting of dan administrator or de monitoring systems compliance. Result could be reviewed assurance meeting | areas are kept in good repair. or designee could educate all n the policies and procedures nage or need for repair. The signee could develop s to ensure ongoing ts of these monitoring/audits at the quarterly quality gs. R CORRECTION: Twenty-one | | | | |