Minnesota Department of Health

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.

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.

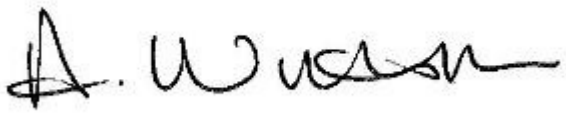
The surveyor also observed the resident to display non-verbal and verbal signs of pain to the right arm/hand on July 20, 2016 at 11:00 a.m., 12:47 p.m., 2:29 p.m. and 7:15 p.m., and again on July 21, 2016 at 10:09 a.m.

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,



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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BU2K

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00682

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245388**

2. STATE VENDOR OR MEDICAID NO. (L2) **593043000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKESHORE INN NURSING HOME**
(L4) **108 8TH STREET NORTHWEST**
(L5) **WASECA, MN** (L6) **56093**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **9/6/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : Susan Kalis, HFE NE II 9/13/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Health Program Representative 09/13/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

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.

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: Kamala.Fiske-Downing@state.mn.us

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245388 Y1	A. Building B. Wing 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 qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0318	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 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
Reg. # 483.70(h)	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	DATE
	/KS/kfd	9/13/2016	37041	9/6/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/21/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245388 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/13/2016 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 qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	08/12/2016	LSC K0038	08/22/2016	LSC K0056	09/13/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0062	08/12/2016	LSC K0072	08/12/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	9/13/2016	37008	9/13/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/21/2016

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

Minnesota Department of Health

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.

Kamala 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: Kamala.Fiske-Downing@state.mn.us

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00682 Y1	A. Building B. Wing 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565	Correction	ID Prefix 20830	Correction	ID Prefix 20895	Correction
Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0520 Subp. 1	Completed	Reg. # MN Rule 4658.0525 Subp. 2.B	Completed
LSC	08/25/2016	LSC	08/22/2016	LSC	08/25/2016
ID Prefix 21390	Correction	ID Prefix 21695	Correction	ID Prefix	Correction
Reg. # MN Rule 4658.0800 Subp. 4 A-I	Completed	Reg. # MN Rule 4658.1415 Subp. 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		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	9/13/2016	37041	9/6/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/21/2016

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BU2K

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00682

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245388**

2. STATE VENDOR OR MEDICAID NO. (L2) **593043000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKESHORE INN NURSING HOME**
(L4) **108 8TH STREET NORTHWEST**
(L5) **WASECA, MN** (L6) **56093**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **07/21/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susan Kalis, HFE NE II 08/23/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 08/31/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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;

- 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.

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

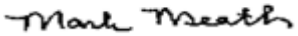
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

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

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

Sincerely,



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245388	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE INN NURSING HOME	108 8TH STREET NORTHWEST WASECA, MN 56093

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care developed to maintain mobility and range of motion (ROM) for 2 of 3 residents (R33, R2) reviewed for range of motion. Findings include: R33 was admitted with diagnoses which included progressive supranuclear palsy (brain disorder which affects movement), Parkinsonism, osteoporosis, diabetes, anxiety and depression. Review of the care plan did not identify the ROM program, but it was identified on the treatment	F 282	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.	8/25/16

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

Electronically Signed | 08/12/2016

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F 282	Continued From page 1 record and flow sheet utilized by NAs to document the ROM activities. Review of the medical record indicated R33 received physical therapy (PT) with a start of care date of 1/13/16, and end of care date of 3/2/16. The daily treatment note dated 3/2/16, stated "Patient progress has plateaued. Patients restorative nursing program reviewed with physical therapy assistant (PTA). Nursing staff has been instructed in ROM. This program will continue under supervision of nursing staff. At this time patient continues to remain completely dependent on all cares. Patient reports that discomfort in the right upper arm has decreased to a mild level. Patient's treatment supervision discontinued (by PT). Nursing staff to continue with a maintenance range of motion program under their supervision." The PT discharge summary dated 3/2/16, identified: Patient/Caregiver Training: Nursing staff instructed in AROM exercises. Discharge plans and instructions: Patient will remain a resident of this extended care facility and will receive a restorative nursing program for ROM. Individualized exercise program dated 12/14/15, detailed an exercise program to be provided. A note was provided for direct care staff with the individualized program identified. Following the program a handwritten note dated 2/25/16, identified PROM BUE and BLEs BID, Morning and Evening. The individualized program directed 5 repetitions of each exercise to be completed with each session. During observation on 7/19/16, at 6:03 p.m. NA-B provided bedtime (HS) care for R33. R33 did not move her left hand or arm and it remained in an elbow bent position, held against her body. R33's right arm was stiff and resistant to movement.	F 282	A mandatory CNA inservice will be held on August 23rd, 2016 and August 25th, 2016 to train CNA□s on proper ROM technique and to review general ROM instructions. CNA□s will be instructed on reporting refusals of ROM or pain indicators during ROM to their charge nurse. CNA□s will also be instructed on importance of following plan of care. DON□s will randomly audit 20% of residents weekly times one month, then monthly times two months to ensure that they are receiving appropriate ROM and that the staff are following the care plan. Results of audits will be presented at the November 2016 QA meeting. ROM police revised.	

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F 282	Continued From page 2	F 282		

Following the provision of personal cares and dressing in night clothes, R33 was transferred from the toilet utilizing the stand up lift and was positioned on the side of the bed. R33's body position remained stiff with head forward toward her chest, and ankles pronated downward and toes pointed. Both NAs positioned R33 so she was lying on her back in the bed. Once positioned on the bed R33 was noted to have a rolled cloth in her left hand. The fingers of both hands were in a curled position. No attempt was made to remove cloth and/or wash R33's palms or under fingers. At 6:34 p.m. NA-B positioned a pillow under R33's left arm, and asked if it was alright to provide exercise at this time. R33 verbalized agreement and NA-B provided ROM to the upper right arm and both lower legs performing a total of three (3) repetitions for each limb. Positioned resident for comfort, NA-B stated R33's cares were complete and this was the usual routine for personal cares and ROM. NA-B stated therapy did the ROM on R33's right arm. Licensed practical nurse (LPN)-A was interviewed on 7/20/16, at 7:55 a.m. and stated R33 was very rigid and needed full assist. LPN-A further stated R33 was supposed to receive ROM to all extremities twice a day morning and evening.

On 7/20/16, at 1:17 p.m. NA-A was interviewed and stated R33 was positioned in her bed or chair by staff and a pillow was placed under her left arm and a roll was placed into her left hand. NA-A indicted R33 received ROM exercises to her lower body but was not aware of any ROM that was supposed to be provided for the upper body.
Review of the NA flow sheet for 7/16 indicated R33 received ROM exercise in the PM but nothing was documented as having been

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F 282	Continued From page 3	F 282		

provided in the AM.
Request was made for a policy addressing ROM and restorative programs, but nothing was provided.
Physician orders signed 7/19/16, identified R2 as being admitted to the facility on 10/14/15, with diagnosis including cerebral vascular accident (CVA) with hemiplegia (paralysis) affecting the right side.

The quarterly Minimum Data Set (MDS) dated 4/26/16, identified moderate cognitive impairment, extensive assistance needed with all activities of daily living (ADL's) and a functional limitation of upper and lower extremities. The admission Care Area Assessment (CAA) dated 10/27/15, identified R2 as having a history of a CVA (cerebral vascular accident) with right hemiplegia. Staff provided extensive to total assistance with all ADL's. R2 did not walk, transferred with a mechanical lift and received PT (physical therapy) and OT (occupational therapy) to increase strength and mobility.

Review of the current nursing assistant care sheet identified R2 as receiving ROM (range of motion) everyday as tolerated, slow/gentle. A PT note dated 3/30/16, indicated plan to discharge patient from formal physical therapy by end of this week. A PROM (passive range of motion) program was to continue for right lower extremity (RLE) and right upper extremity (RUE) as well as a strengthening program for maintenance.

R2 also received PT (physical therapy) from 10/15/15, to 12/7/15. Review of the PT Therapist Progress & Discharge Summary dated 12/7/15, identified that nursing staff was instructed in a maintenance range of motion program.

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F 282	Continued From page 4 On 7/20/16, at 7:15 a.m. R2 was observed sitting up in wheelchair. R2 was unable to open his right hand. R2 stated it hurt if he tried to open it. No splint or palm protector was in place. Nursing assistant (NA)-A got R2 up for the day and stated staff didn't do any exercises with R2. On 7/20/15, at 10:08 a.m. COTA-B stated OT had previously worked with R2 with ROM to the affected side to see if ROM could be improved. He stated R2's hand was not contracted at that time and R2 had reached a plateau so OT was discontinued. He also stated OT did not look at R2 for a splint program. He stated the facility did not have a restorative program so if nursing deemed it appropriate they could get a physician's order and evaluate R2 for PT or OT. On 7/20/16, at 11:10 a.m. NA-B stated, "he can't open his hand it hurts too much." Additionally NA-B stated staff did not do exercises on R2 "At one time he had a brace but I don't know what happened to it." On 7/20/16, at 12:37 p.m. physical therapy assistant (PTA)-A stated R2 was on a maintenance program for ROM mainly for the right side to prevent contractures. She indicated that PT wrote up a program for nursing and talked to staff to make sure they were continuing with ROM to prevent contractures. She also stated, "they should be doing it daily." On 7/21/16, at 9:15 a.m. NA-C stated she had done morning cares for R2. "We don't do ROM for him as it is too painful." On 7/21/16, at 10:08 a.m. NA-D stated,	F 282		

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F 282	Continued From page 5 "sometimes I try to do a little ROM on him but he is usually resistive so I don't do it." On 7/21/16, at 10:30 a.m. registered nurse (RN)-A verified R2 should be receiving ROM daily as identified by the flow sheet. She stated the NA's learn ROM in NA class. RN-A further stated they usually did it 5-10 minutes. She stated the NA flow sheet should have identified where the ROM was being done. RN-A stated if R2 was refusing or staff was not completing the ROM the nurse should be notified. A policy on ROM was requested but none was provided by the facility.	F 282		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to assess pain and provide adequate pain control for 1 of 1 residents (R2) reviewed for pain. This resulted in harm for R2 as he experienced moderate to severe pain on a daily basis that remained unassessed and untreated. Therapy notes identify R2 had untreated pain going back to date of admission.	F 309	R2 was set up on Tylenol 500mg po bid routinely and daily pain assessments set up. NP will review pain on August rounds. Order obtained for therapy evaluation. R2□s care plan updated to include pain interventions. Facility pain policy was reviewed and updated.	8/22/16

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F 309	Continued From page 6 Findings include: Physician orders signed 7/19/16, identified R2 was admitted to the facility on 10/14/15, with diagnosis including a cerebral vascular accident (CVA) with hemiplegia (paralysis) affecting right side and expressive aphasia (loss of the ability to express language). The quarterly Minimum Data Set (MDS) dated 4/26/16, identified moderate cognitive impairment, extensive assistance needed with all activities of daily living (ADL's) and a functional limitation of upper and lower extremities. The admission Care Area Assessment (CAA) dated 10/27/15, identified R2 as having a history of a CVA with right hemiplegia. Staff provide extensive to total assistance with all ADL's. R2 did not walk, transferred with a mechanical lift and received PT (physical therapy) and OT (occupational therapy) to increase strength and mobility. During observation on 7/19/16, at 6:00 p.m. P2 was observed to grimace any time the right arm/hand was touched or he attempted to move it. P2 was observed to lift his right hand/arm up with his left hand and stated "Ouch!" When asked if it hurt he nodded his head yes. On 7/20/16, at 7:15 a.m. R2 was observed sitting up in the wheelchair. R2 was unable to open his right hand. R2 stated it hurt if he tried to open it. On 7/20/16, at 11:00 a.m. R2 was observed sitting up in the wheelchair. R2 had his right hand clenched. When asked if he could open his hand he shook his head no and indicated it hurt if he tried. When his arm was lightly touched, R2	F 309	A nurses meeting will be held on August 22, 2016 to review the facility□s pain management policy. Pain management education materials put at nurses stations for CNA□s to review. CNA□s instructed to report pain indicators (verbal and non verbal) to their charge nurse. Pain assessments will be administered upon admission and upon recognition of discomfort. Based on assessment, nursing staff will determine whether pain medications should be given and if physician needs to be notified. DON□s will randomly audit 20% of residents weekly times for one month, then monthly times two months to determine if they are experiencing pain and if current pain regime is appropriate. The results of audits will be reported at November 2016 QA meeting.	

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F 309	Continued From page 7 grimaced. On 7/20/16, at 12:47 p.m. OTRL (occupational therapist registered licensed)-A observed R2 in the dining room. When OTRL-A touched R2's right arm/hand, he grimaced with pain and loudly stated "ouch!" OTRL stated she had worked with R2 in occupational therapy (OT) in the fall and she recalled that R2's right side was very sensitive. On 7/20/16, at 2:29 p.m. R2 was observed sitting in the dining room with his wife. His wife attempted to lift his right arm/hand to look at his hand. R2 was observed to grimace. When asked if it hurt, he nodded his head yes. R2's wife stated, "it does really seem to hurt him." On 7/21/16, at 8:32 a.m. R2 was again observed in the dining room. When asked about his right arm/hand, he shrugged his shoulders. R2 was unable to open his hand and when he attempted to lift arm/hand he grimaced and expressed pain. On 7/21/16, at 10:09 a.m. nursing assistant (NA)-E and NA-F were observed using the EZ lift (mechanical lift device) to lay R2 in bed. When NA-F attempted to lift his right arm to hold onto the EZ lift R2 cried out, "No! No! Ouch! Ouch!" NA-F asked R2 what his pain level was and R2 stated "7" (on a scale of 0-10 with 10 being the most pain). Review of the medical record identified R2 had received OT from 10/15/15 to 12/8/15. OT notes included: 10/29/16 - [R2] was not wearing right resting splint on therapist arrival. Pt presents with significant pain and contracture/limited PROM	F 309		

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(passive range of motion) in RUE (right upper extremity).
11/3/15 - [R2] care conference was held with wife and daughters. Many concerns were discussed including RUE pain management.
11/9/15 - PROM very limited due to [R2] reporting pain and refusing.
11/16/15 - [R2] had significant pain in right hand and forearm today.
11/20/15 - [R2] complained of discomfort at times.
11/23/15 - PROM RUE with limited ROM and complaints of pain.
11/25/15 - did not verbalize pain but grimaced with movement with PROM.
11/26/15 - PROM with maximum complaints of pain, OT only able to do minimal ROM.
11/27/15 - [R2] has stiff digits and extension caused pain in RUE.
12/2/15 - Limited PROM as [R2] would not allow due to pain.
12/8/15 - noted right hand joint contracture, [R2] tolerated gentle PROM.
12/8/15 - Therapist Progress & Discharge Summary dated identified [R2] reports pain in right hand to severe on 10/29/15, pain in right hand to mild on 11/25/15 and pain in right hand to mild but demonstrated facial grimaces and verbalizations during ROM to indicate pain is moderate on 12/8/15.

Review of the medication administration records (MAR) from April 2016, to July 2016, identified R2 had an order for Tylenol 500 milligrams (mg) every 4 hours as needed (PRN) for pain. Documentation indicated R2 had received Tylenol 500 mg once in April of 2016, 5 times in May 2016, 6 times in June 2016, and none in July 2016. Review of the nurses' notes clarified of the 12 times the PRN Tylenol was given, it had been

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LAKESHORE INN NURSING HOME	108 8TH STREET NORTHWEST WASECA, MN 56093

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given 3 times for an elevated temperature and 9 times for pain. Nursing notes identified on 5/24/16, R2 complained of pain "all over" and had identified a pain level of 5 of 10 (0 not pain, 10 being worst pain). On 5/26/16, R2 had "vocal complaints of pain (that hurts, ouch, stop). On 5/29/16, R2 had expressed pain "all over" and a pain level of 5. On 6/1/16, R2 complained of pain "all over" and a pain level of 4. On 6/2/16, R2 again complained of pain "all over" and rated the pain at a level 5. On 6/3/16, R2 complained of pain "all over" and rated the pain level as 5. On 6/6/16, R2 complained of pain "all over" and rated his pain level as 6. On 6/11/16, R2 had pain "all over" and rated his pain level as 4. On 6/12/16, R2 had pain "all over" and rated the pain level as 5.

The Pain Management Policy revised 8/03, identified the facility pain protocol included identifying the intensity of pain using a 0-5 scale (5 as the highest amount of pain). Although this was the facility policy, staff did not consistently utilize this scale as evidenced by R2 rating his pain greater than 5. There was no documentation with the PRN Tylenol to identify what pain scale was used or the level of relief obtained with the administration of Tylenol. Further, without a pain assessment, there was no evidence of what an acceptable level of pain was for R2. In addition, it was unclear what R2's level of pain was with movement, at rest, and at rest following movement.

The care plan dated 10/26/15, identified impaired mobility due to history of cerebral vascular accident with right hemiplegia and identified an approach of "assure adequate pain management." There were no interventions

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identified. Without a comprehensive assessment for pain, there were no individualized pain management approaches identified for R2.

On 7/20/16, at 11:10 a.m. NA-B stated, "he can't open his hand it hurts too much."

On 7/21/16, at 9:15 a.m. NA-C stated she did morning cares for R2. She stated, "we don't do ROM for him as it is too painful." She stated R2 really complained of pain when staff try to lift his right side. NA-C stated she let the nurse know if pain is more than usual. She stated the nurse was aware that it bothered him to move too fast.

On 7/21/16, at 10:08 a.m. NA-D stated, "sometimes I try to do a little ROM on him but he is usually resistive because it hurts him so I don't do it."

On 7/21/16, at 9:40 a.m. licensed practical nurse (LPN)-A stated the aides had not reported R2 stated he had pain. She stated "I think he just doesn't like anyone touching that arm."

On 7/21/16, at 11:00 a.m. registered nurse (RN)-B verified a pain assessment should have been completed on R2 and staff should have been reporting increased pain to nurse.

The Pain Management Policy revised 8/03, identified it was facility policy to assess the amount of pain a resident was experiencing and to evaluate the analgesic prescribed. The facility pain protocol included identifying the intensity of pain using a 0-5 scale (5 as the highest amount of pain), analgesic used, plan and comments and efficacy of pharmacological and non-pharmacological interventions. The policy

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F 309	Continued From page 11 also indicated an ongoing pain management plan would be addressed on the resident's care plan.	F 309		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide range of motion (ROM) services to maximize strength and mobility for 2 of 3 residents (R33, R2) reviewed for range of motion services. Findings include: R33 was admitted with diagnoses which included progressive supranuclear palsy (brain disorder which affects movement), Parkinsonism, osteoporosis, diabetes, anxiety and depression. Review of the medical record indicated R33 received physical therapy (PT) with a start of care date of 1/13/16, and end of care date of 3/2/16. The daily treatment note dated 3/2/16, stated "Patient progress has plateaued. Patients restorative nursing program reviewed with physical therapy assistant (PTA). Nursing staff has been instructed in ROM. This program will continue under supervision of nursing staff. At this time patient continues to remain completely dependent on all cares. Patient reports that discomfort in the right upper arm has decreased	F 318	Physicians for R2 and R33 were contacted and orders were obtained for therapy evaluations. Both residents care plans and CNA flow sheets were updated to reflect the current range of motion plan. All residents were evaluated for current range of motion plan. Changes were made as needed. Physicians orders were obtained for residents that needed PT/OT evaluations. All care plans and CNA flow sheets were updated to include current ROM plans. The therapy department provided a list of common abbreviations, general instructions for ROM and pictures of several ROM exercises. This information was placed in all the CNA flow books. When a resident is discharged from therapy, the therapy manager will discuss	8/25/16

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F 318	Continued From page 12 to a mild level. Patient's treatment supervision discontinued (by PT). Nursing staff to continue with a maintenance range of motion program under their supervision." PT daily treatment notes identified: 2/16/16: received passive range of motion (PROM) with end stretch bilateral upper extremities(BUE) and bilateral lower extremities (BLE) to improve ROM for wheelchair (W/C) positioning and comfort. 2/18/16: Resident reports PROM feels good. Tolerated PROM to BUE and BLE with gentle end range stretch to all joints and resident tolerance x 10 repetitions. Active ROM (AROM) to right UE at fingers, wrist, elbow and shoulder x 10 repetitions. Tolerated session well. Continue with current plan of care to increase ROM and decrease pain. 2/24/16: Patient received PROM LLE AND LUE and AROM RUE and RLE with end stretch. Instructed nursing assistant (NA)[-B] in PROM and AROM programs. Discussed the plan to discharge patient to a restorative nursing program on a PROM program. 2/25/16: Instructed 3 NA staff (individuals not identified), in PROM to be done twice a day (BID) once in the a.m. before getting out of bed and once in p.m. before going to bed.. Spoke with night nurse regarding program follow up. The PT discharge summary dated 3/2/16, identified: Patient/Caregiver Training: Nursing staff instructed in AROM exercises. Discharge plans and instructions: Patient will remain a resident of this extended care facility and will receive a restorative nursing program for ROM. Individualized exercise program dated 12/14/15, detailed an exercise program to be provided. A note was provided for direct care staff with the individualized program identified. Following the	F 318	ROM needs with the DON□s and charge nurse, and a program will be implemented at that time if necessary. A mandatory CNA inservice will be held on August 23rd, 2016 and August 25th, 2016 to train on proper ROM techniques and to review general ROM instructions. CNA□s will be educated on reporting refusals of ROM or pain indicators during ROM to their charge nurse. DON□s will randomly audit 20% of residents weekly times one month, then monthly times two months to ensure that they are receiving appropriate ROM and that the staff are following the care plan. Results of audits will be presented at November 2016 QA meeting. Range of motion police revised.	

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program a handwritten note dated 2/25/16, identified PROM BUE and BLEs BID, Morning and Evening. The individualized program directed 5 repetitions of each exercise to be completed with each session.
During observation on 7/19/16, at 6:03 p.m. NA-B provided bedtime (HS) care for R33. R33 was not observed to assist with position changes or transfer from chair to toilet or bed and a stand lift was utilized. R33 did not move her left hand or arm and it remained in an elbow bent position, held against her body. NA-C came into the room and assisted with washing resident. Both NA-B and NA-C assisted with dressing R33's upper body. R33's right arm was stiff and resistant to movement. Following the provision of personal cares and dressing in night clothes, R33 was transferred from the toilet utilizing the stand up lift and was positioned on the side of the bed. R33's body position remained stiff with head forward toward her chest, and ankles pronated downward and toes pointed. Both NAs positioned R33 so she was lying on her back in the bed. Once positioned on the bed R33 was noted to have a rolled cloth in her left hand. The fingers of both hands were in a curled position. No attempt was made to remove cloth and/or wash R33's palms or under fingers. At 6:34 p.m. NA-B positioned a pillow under R33's left arm, and asked if it was alright to provide exercise at this time. R33 verbalized agreement and NA-B provided ROM to upper right arm and both lower legs performing a total of three (3) repetitions for each limb. Positioned resident for comfort, NA-B stated R33's cares were complete and this was the usual routine for personal cares and ROM. NA-B stated therapy did the ROM on R33's right arm.
Licensed practical nurse (LPN)-A was interviewed on 7/20/16, at 7:55 a.m. and stated R33 required

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total assistance with activities of daily living (ADLs) and that she was very rigid and needed full assist. LPN-A further stated R33 was supposed to receive ROM to all extremities twice a day morning and evening. In addition LPN-A reported the decline in ADL status had been discussed at the most recent care conference on 7/18/16. It was also indicated R33 had a skin tear on the posterior surface of her left hand and this was thought to be the result of using the lift and R33's inability to grip with her left hand.

On 7/20/16, at 1:17 p.m. NA-A was interviewed and stated R33 was positioned in her bed or chair by staff and a pillow was placed under her left arm and a roll was placed into her left hand. NA-A indicted R33 received ROM exercises to her lower body but was not aware of any ROM that was supposed to be provided for the upper body.
Review of the NA flow sheet for 7/16 indicated R33 received ROM exercise in the PM but nothing was documented as having been provided in the AM.
Review of the care plan did not identify the ROM program, but it was identified on the treatment record and flow sheet utilized by NAs to document the ROM activities
Request was made for a policy addressing ROM and restorative programs, but nothing was provided.
Physician orders signed 7/19/16, identified R2 was admitted to the facility on 10/14/15, with diagnoses including a cerebral vascular accident (CVA) with hemiplegia (paralysis) affecting the right side.

The quarterly Minimum Data Set (MDS) dated 4/26/16, identified moderate cognitive

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impairment, extensive assistance needed with all activities of daily living (ADL's) and a functional limitation of upper and lower extremities. The admission Care Area Assessment (CAA) dated 10/27/15, identified R2 as having a history of a CVA (cerebral vascular accident) with right hemiplegia. Staff provided extensive to total assistance with all ADL's. R2 did not walk, transferred with a mechanical lift and received PT (physical therapy) and OT (occupational therapy) to increase strength and mobility.

Review of the current nursing assistant care sheet identified R2 was receiving ROM (range of motion) everyday as tolerated, slow/gentle. A PT note dated 3/30/16, indicated a plan to discharge patient from formal physical therapy by end of this week. A PROM (passive range of motion) program was to continue for right lower extremity (RLE) and right upper extremity (RUE) as well as a strengthening program for maintenance.

R2 received occupational therapy (OT) from 10/15/15, to 12/8/15. Review of the OT notes identified :
10/26/15, mild to moderate contractures present in hand. A trial of a right resting splint was initiated to maintain skin integrity and prevent further contracture.
10/29/15, pt was not wearing right resting splint and significant contracture/limited prom was noted in the RUE. Pt's wife had brought in a splint R2 had from a previous hospitalization but the splint did not address finger contractures. A temporary resting splint was placed on R2's right hand.
11/2/15, a new resting splint was ordered for R2. The splint that was available at the facilty was placed temporarily on R2's right arm/hand.

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F 318	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 resting 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		

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protection and contracture management" This goal was identified as being met on 12/8/15.

R2 also received PT (physical therapy) from 10/15/15, to 12/7/15. Review of the PT Therapist Progress & Discharge Summary dated 12/7/15, identified that nursing staff was instructed in a maintenance range of motion program.

On 7/20/16, at 7:15 a.m. R2 was observed sitting up in wheelchair. R2 was unable to open his right hand. R2 stated it hurt if he tried to open it. No splint or palm protector was in place. Nursing assistant (NA)-A got R2 up for the day and stated staff didn't do any exercises with R2.

On 7/20/15, at 10:08 a.m. COTA-B stated OT had previously worked with R2 with ROM to the affected side to see if ROM could be improved. He stated R2's hand was not contracted at that time and R2 had reached a plateau so OT was discontinued. He also stated OT did not look at R2 for a splint program. He stated the facility did not have a restorative program so if nursing deemed it appropriate they could get a physician's order and evaluate R2 for PT or OT.

On 7/20/16, at 11:10 a.m. NA-B stated, "he can't open his hand it hurts too much." Additionally NA-B state staff did not do exercises on R2 "At one time he had a brace but I don't know what happened to it."

On 7/20/16, at 12:29 p.m. OTRL (occupational therapist registered licensed)-A stated OT worked with R2 for a splint for the right arm/hand. She stated it was passed on to nursing to set up the splint schedule in 12/15. OTRL-A observed R2 and stated his hand was not any worse (more

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contracted) than it was before. She thought his wife brought in a splint but they tried a different one, she did not remember if it worked for R2 or not.

On 7/20/16, at 12:37 p.m. physical therapy assistant (PTA)-A stated R2 was on a maintenance program for ROM mainly for the right side to prevent contractures. She indicated that PT wrote up a program for nursing and talked to staff to make sure they were continuing with ROM to prevent contractures. She also stated, "they should be doing it daily."

On 7/20/16, at 2:29 p.m. R2's wife was interviewed. She stated she never had a splint for him at home and had not brought one to the facility. However, she thought that would be a good idea.

On 7/21/16, at 9:15 a.m. NA-C stated she had done morning cares for R2. "We don't do ROM for him as it is too painful."

On 7/21/16, at 10:08 a.m. NA-D stated, "sometimes I try to do a little ROM on him but he is usually resistive so I don't do it."

On 7/21/16, at 10:30 a.m. registered nurse (RN)-A verified R2 should be receiving ROM daily as identified by the flow sheet. She stated the NA's learn ROM in NA class. RN-A further stated they usually did it 5-10 minutes. She stated the NA flow sheet should have identified where the ROM was being done. RN-A stated if R2 was refusing or staff was not completing the ROM the nurse should be notified. She was unaware that OT had recommended the use of a palm protector and stated that should have been

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F 318	Continued From page 19 communicated and placed on the NA flow sheets. A policy on ROM was requested but none was provided by the facility.	F 318		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a clean, sanitary environment, and resident rooms in good repair, for 11 of 30 residents. Findings include: Observations noted during the initial tour on 7/18/16, and verified on 7/21/16, at 12:50 p.m. with the environmental director (ED) were as follows: 1. R1's bathroom wall was damaged, the wall bulged outward along the floor board. The wall was cracked open, and revealed a black, loose, wet, substance that was visible inside the wall. The paint and surface around the opening was moist and easily crumbled away when touched. The opening was approximately 18 inches long and gapped 4 inches. Family member (FM)-A identified that she reported the damaged wall in 4/16, but no repairs had been completed. While in the room the ED verified he was aware of the	F 465	Since the survey, we have created a "maintenance room check list". Each room has a checklist that will be reviewed at least annually, and more often as needed, or communicated to our maintenance staff. Dining room problem areas have been addressed - painted, touched up, cleaned and frosted (Plexiglas). Resident rooms, where properly identified on the resident list provided to us by the survey team, have had holes patched, door frames painted, sheet rock repaired, restrooms repaired as well. Without knowing all of the residents sited in the 2567, we cannot guarantee that all items have been rectified, but we believe we have fixed all of the items on the list. All rooms will be checked, using the new checklist, by 8/31/16. Work will be done as deemed necessary and work shall be	9/5/16

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F 465	Continued From page 20 damaged wall. 2. R57's bathroom had a pungent foul urine odor. The white tiles with grout had black debris and were discolored. 3. R20's bathroom had a strong urine odor that could be detected at the entry door to the room. 4. R14's bathroom had a strong malodorous smell which seemed to concentrate by the entryway to the room. The bathroom door was noted to be heavily scraped, with missing paint and surface damage. 5. R1's bathroom had a strong urine odor. There were 1 to 2 inch holes and gouges noted on the bathroom walls, especially prevalent around the sink. The door frames to the room, and to the bathroom, were heavily scraped, with paint chipped off. 6. R25's bathroom and entry door frames, were noted to be heavily scraped with black marks and revealed paint removed and surface damage. 7. R13's room revealed holes in the wall, that were in need of repair. The walls in the room were marked with black marks. The entry and bathroom door frames, were marked with black marks and the surface was heavily scraped and damaged. 8. R45's wall on the left side of the window, had a 2 inch gouge to the sheet rock, the paint and surface was heavily scraped. 9. R39's ceiling tile was cracked completely across the tile. 10. R41's wall behind her chair was damaged covering an area 4 x 3 feet. The surface was bubbled, and when touched was full of moisture, which crumbled. The paint was releasing from moisture. 11. R38's walls revealed holes, black marking, severe scrapes, and paint missing. The resident stated that they have been there since she	F 465	completed by 9/5/16. Director of Maintenance will report to the QA committee the progress of work and update the committee on the use of the "maintenance room check list".	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245388	A. BUILDING _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE INN NURSING HOME	108 8TH STREET NORTHWEST WASECA, MN 56093

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 21	F 465		

moved in a year ago. The corners of the bathroom had a build up of debris, and the grout was stained, brown and yellow and crumbled away when touched. The bathroom and entry door frames, were stained, had black marks, and were heavily scraped with surface damage.
12. The lower 3 feet of the dining room walls were heavily scraped, black marks were evident, and paint was missing. Sections of wall paper were surface damaged, and releasing from the wall revealing the sheet rock underneath. The Plexiglass walls surrounding the coffee serving area were stained, and the surface was scraped, and surface damaged.

During the tour the ED stated at 1:30 p.m. he had a quarterly schedule to make the necessary environmental repairs (e.g.. walls, floors, tile). However upon request he was unable to submit any such schedule. The ED stated the housekeeping staff cleaned each room and bathroom daily. He was unsure why the odors existed, and turned on three bathroom exhaust fans during the tour. The ED stated the housekeepers were responsible to report when repairs were needed. When in the west wing the ED presented a clip board that was used for communication, when there were environmental issues in need of repair. There were no notes on the communication board.

Review of the policy dated as revised 1/15, Housekeeping Infection Control Guidelines included patient bathroom wall tile was scrubbed every six months with disinfectant. The policy dated as revised 1/14, titled Building Maintenance Policy identified routine building maintenance was to be performed daily by the maintenance staff, with input from other departments utilizing the

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	245388	A. BUILDING _____ B. WING _____	07/21/2016

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F 465	Continued From page 22 repair sheets located in the South Wing and one on the East Wing. Staff nurses were instructed to contact maintenance staff immediately if something needed to be repaired sooner. On a semi-annual basis, coinciding with the housekeeping department's waxing of resident room floors, maintenance staff went through the rooms to repair any items in need of touch up. The checklist included: paint, windows, doors, cabinets, closets and walls (nails, paint, and wallpaper).	F 465		

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	245388	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE INN NURSING HOME	**108 8TH STREET NORTHWEST** **WASECA, MN 56093**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated July 21, 2016, Lakeshore Inn Nursing Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/12/2016

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

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	245388	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/21/2016**

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LAKESHORE INN NURSING HOME	**108 8TH STREET NORTHWEST** **WASECA, MN 56093**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lake Shore Inn Nursing Home is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1960 and was determined to be of Type II(111) construction. In 1968, addition was constructed to the South Wing that was determined to be of Type II(111) construction. In 1984, another addition was added to the South Wing and was determined to be Type II (111). In 1998, an addition was added to the East Wing and was determined to be Type II (111) construction. Because the original building and the 3 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.	K 000		

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	245388	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE INN NURSING HOME	**108 8TH STREET NORTHWEST** **WASECA, MN 56093**

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K 000	Continued From page 2 The facility has a capacity of 55 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 On facility tour between 09:00 AM and 01:00 PM on July 21, 2016, observation revealed that a penetration around a 2" fire sprinkler pipe was found above the smoke barrier doors in the east wing. .	K 025	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.	8/12/16
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 On facility tour between 09:00 AM and 01:00 PM	K 038	We have ordered a panic bar for the exit door in the dining room. The hardware will be installed next week.	8/22/16

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	245388	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/21/2016**

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LAKESHORE INN NURSING HOME	**108 8TH STREET NORTHWEST WASECA, MN 56093**

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K 038	Continued From page 3 on July 21, 2016, observation revealed that the exit door in the dinning room to outside area would not open and has a door handle and dead lock lock on door. Door is required to have panic hardware..	K 038	Director of Maintenance will arrange for the work to be done.	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 On facility tour between 09:00 AM and 01:00 PM on July21, 2016, observation revealed that there is no fire protection in west link to 2 hour fire rated doors in the addition to assessed living building. .	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
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		8/12/16

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K 062 SS=D	Continued From page 4 Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 On facility tour between 09:00 AM and 01:00 PM on July 21, 2016, observation revealed that there are missing ceiling found around new equipment in the physical therapy room.	K 062	The ceiling tile in the therapy room has been replaced. Director of Maintenance will monitor the building for any missing tiles and replace as he finds problems.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress shall be continuously maintained free of all obstructions or impediments to full	K 072		8/12/16

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LAKESHORE INN NURSING HOME	**108 8TH STREET NORTHWEST** **WASECA, MN 56093**

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K 072	Continued From page 5 instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 This STANDARD is not met as evidenced by: Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1 On facility tour between 09:00 AM and 01:00 PM on July 21, 2016, observation revealed storage was found in the east exit hallway to outside door..	K 072	All items have been removed from the exit hallway. Items will no longer be stored there. Director of Maintenance will periodically check the hallway to make certain no staff have mistakenly placed storage in any exit areas.	

Minnesota Department of Health

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

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

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

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

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

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00682	A. BUILDING: _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE INN NURSING HOME	108 8TH STREET NORTHWEST WASECA, MN 56093

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On July 18th, 19th, 20th and 21st 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care developed to maintain mobility and range of motion (ROM) for 2 of 3 residents (R33, R2) reviewed for range of motion. Findings include: R33 was admitted with diagnoses which included progressive supranuclear palsy (brain disorder which affects movement), Parkinsonism, osteoporosis, diabetes, anxiety and depression. Review of the care plan did not identify the ROM program, but it was identified on the treatment record and flow sheet utilized by NAs to document the ROM activities. Review of the medical record indicated R33 received physical therapy (PT) with a start of care date of 1/13/16, and end of care date of 3/2/16. The daily treatment note dated 3/2/16, stated "Patient progress has plateaued. Patients	2 565	Corrected.	8/25/16

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2 565	Continued From page 3	2 565		

restorative nursing program reviewed with physical therapy assistant (PTA). Nursing staff has been instructed in ROM. This program will continue under supervision of nursing staff. At this time patient continues to remain completely dependent on all cares. Patient reports that discomfort in the right upper arm has decreased to a mild level. Patient's treatment supervision discontinued (by PT). Nursing staff to continue with a maintenance range of motion program under their supervision."
The PT discharge summary dated 3/2/16, identified: Patient/Caregiver Training: Nursing staff instructed in AROM exercises. Discharge plans and instructions: Patient will remain a resident of this extended care facility and will receive a restorative nursing program for ROM.
Individualized exercise program dated 12/14/15, detailed an exercise program to be provided. A note was provided for direct care staff with the individualized program identified. Following the program a handwritten note dated 2/25/16, identified PROM BUE and BLEs BID, Morning and Evening. The individualized program directed 5 repetitions of each exercise to be completed with each session.
During observation on 7/19/16, at 6:03 p.m. NA-B provided bedtime (HS) care for R33. R33 did not move her left hand or arm and it remained in an elbow bent position, held against her body. R33's right arm was stiff and resistant to movement. Following the provision of personal cares and dressing in night clothes, R33 was transferred from the toilet utilizing the stand up lift and was positioned on the side of the bed. R33's body position remained stiff with head forward toward her chest, and ankles pronated downward and toes pointed. Both NAs positioned R33 so she was lying on her back in the bed. Once positioned on the bed R33 was noted to have a

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2 565	Continued From page 4	2 565		

rolled cloth in her left hand. The fingers of both hands were in a curled position. No attempt was made to remove cloth and/or wash R33's palms or under fingers. At 6:34 p.m. NA-B positioned a pillow under R33's left arm, and asked if it was alright to provide exercise at this time. R33 verbalized agreement and NA-B provided ROM to the upper right arm and both lower legs performing a total of three (3) repetitions for each limb. Positioned resident for comfort, NA-B stated R33's cares were complete and this was the usual routine for personal cares and ROM. NA-B stated therapy did the ROM on R33's right arm.
Licensed practical nurse (LPN)-A was interviewed on 7/20/16, at 7:55 a.m. and stated R33 was very rigid and needed full assist. LPN-A further stated R33 was supposed to receive ROM to all extremities twice a day morning and evening.

On 7/20/16, at 1:17 p.m. NA-A was interviewed and stated R33 was positioned in her bed or chair by staff and a pillow was placed under her left arm and a roll was placed into her left hand.
NA-A indicted R33 received ROM exercises to her lower body but was not aware of any ROM that was supposed to be provided for the upper body.
Review of the NA flow sheet for 7/16 indicated R33 received ROM exercise in the PM but nothing was documented as having been provided in the AM.
Request was made for a policy addressing ROM and restorative programs, but nothing was provided.

Physician orders signed 7/19/16, identifed R2 as being admitted to the facility on 10/14/15, with diagnosis including cerebral vascular accident (CVA) with hemiplegia (paralysis) affecting the right side.

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2 565	Continued From page 5 The quarterly Minimum Data Set (MDS) dated 4/26/16, identified moderate cognitive impairment, extensive assistance needed with all activities of daily living (ADL's) and a functional limitation of upper and lower extremities. The admission Care Area Assessment (CAA) dated 10/27/15, identified R2 as having a history of a CVA (cerebral vascular accident) with right hemiplegia. Staff provided extensive to total assistance with all ADL's. R2 did not walk, transferred with a mechanical lift and received PT (physical therapy) and OT (occupational therapy) to increase strength and mobility. Review of the current nursing assistant care sheet identified R2 as receiving ROM (range of motion) everyday as tolerated, slow/gentle. A PT note dated 3/30/16, indicated plan to discharge patient from formal physical therapy by end of this week. A PROM (passive range of motion) program was to continue for right lower extremity (RLE) and right upper extremity (RUE) as well as a strengthening program for maintenance. R2 also received PT (physical therapy) from 10/15/15, to 12/7/15. Review of the PT Therapist Progress & Discharge Summary dated 12/7/15, identified that nursing staff was instructed in a maintenance range of motion program. On 7/20/16, at 7:15 a.m. R2 was observed sitting up in wheelchair. R2 was unable to open his right hand. R2 stated it hurt if he tried to open it. No splint or palm protector was in place. Nursing assistant (NA)-A got R2 up for the day and stated staff didn't do any exercises with R2. On 7/20/15, at 10:08 a.m. COTA-B stated OT had previously worked with R2 with ROM to the	2 565		

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2 565	Continued From page 6 affected side to see if ROM could be improved. He stated R2's hand was not contracted at that time and R2 had reached a plateau so OT was discontinued. He also stated OT did not look at R2 for a splint program. He stated the facility did not have a restorative program so if nursing deemed it appropriate they could get a physician's order and evaluate R2 for PT or OT. On 7/20/16, at 11:10 a.m. NA-B stated, "he can't open his hand it hurts too much." Additionally NA-B stated staff did not do exercises on R2 "At one time he had a brace but I don't know what happened to it." On 7/20/16, at 12:37 p.m. physical therapy assistant (PTA)-A stated R2 was on a maintenance program for ROM mainly for the right side to prevent contractures. She indicated that PT wrote up a program for nursing and talked to staff to make sure they were continuing with ROM to prevent contractures. She also stated, "they should be doing it daily." On 7/21/16, at 9:15 a.m. NA-C stated she had done morning cares for R2. "We don't do ROM for him as it is too painful." On 7/21/16, at 10:08 a.m. NA-D stated, "sometimes I try to do a little ROM on him but he is usually resistive so I don't do it." On 7/21/16, at 10:30 a.m. registered nurse (RN)-A verified R2 should be receiving ROM daily as identified by the flow sheet. She stated the NA's learn ROM in NA class. RN-A further stated they usually did it 5-10 minutes. She stated the NA flow sheet should have identified where the ROM was being done. RN-A stated if R2 was refusing or staff was not completing the ROM the	2 565		

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2 565	Continued From page 7 nurse should be notified. A policy on ROM was requested but none was provided by the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to assess pain and	2 830	Corrected.	8/22/16

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2 830	Continued From page 8 provide adequate pain control for 1 of 1 residents (R2) reviewed for pain. This resulted in harm for R2 as he experienced moderate to severe pain on a daily basis that remained unassessed and untreated. Therapy notes identify R2 had untreated pain going back to date of admission. Findings include: Physician orders signed 7/19/16, identified R2 was admitted to the facility on 10/14/15, with diagnosis including a cerebral vascular accident (CVA) with hemiplegia (paralysis) affecting right side and expressive aphasia (loss of the ability to express language). The quarterly Minimum Data Set (MDS) dated 4/26/16, identified moderate cognitive impairment, extensive assistance needed with all activities of daily living (ADL's) and a functional limitation of upper and lower extremities. The admission Care Area Assessment (CAA) dated 10/27/15, identified R2 as having a history of a CVA with right hemiplegia. Staff provide extensive to total assistance with all ADL's. R2 did not walk, transferred with a mechanical lift and received PT (physical therapy) and OT (occupational therapy) to increase strength and mobility. During observation on 7/19/16, at 6:00 p.m. P2 was observed to grimace any time the right arm/hand was touched or he attempted to move it. P2 was observed to lift his right hand/arm up with his left hand and stated "Ouch!" When asked if it hurt he nodded his head yes. On 7/20/16, at 7:15 a.m. R2 was observed sitting up in the wheelchair. R2 was unable to open his right hand. R2 stated it hurt if he tried to open it.	2 830		

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2 830	Continued From page 9 On 7/20/16, at 11:00 a.m. R2 was observed sitting up in the wheelchair. R2 had his right hand clenched. When asked if he could open his hand he shook his head no and indicated it hurt if he tried. When his arm was lightly touched, R2 grimaced. On 7/20/16, at 12:47 p.m. OTRL (occupational therapist registered licensed)-A observed R2 in the dining room. When OTRL-A touched R2's right arm/hand, he grimaced with pain and loudly stated "ouch!" OTRL stated she had worked with R2 in occupational therapy (OT) in the fall and she recalled that R2's right side was very sensitive. On 7/20/16, at 2:29 p.m. R2 was observed sitting in the dining room with his wife. His wife attempted to lift his right arm/hand to look at his hand. R2 was observed to grimace. When asked if it hurt, he nodded his head yes. R2's wife stated, "it does really seem to hurt him." On 7/21/16, at 8:32 a.m. R2 was again observed in the dining room. When asked about his right arm/hand, he shrugged his shoulders. R2 was unable to open his hand and when he attempted to lift arm/hand he grimaced and expressed pain. On 7/21/16, at 10:09 a.m. nursing assistant (NA)-E and NA-F were observed using the EZ lift (mechanical lift device) to lay R2 in bed. When NA-F attempted to lift his right arm to hold onto the EZ lift R2 cried out, "No! No! Ouch! Ouch!" NA-F asked R2 what his pain level was and R2 stated "7" (on a scale of 0-10 with 10 being the most pain). Review of the medical record identified R2 had	2 830		

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2 830	Continued From page 10	2 830		

received OT from 10/15/15 to 12/8/15. OT notes included:
10/29/16 - [R2] was not wearing right resting splint on therapist arrival. Pt presents with significant pain and contracture/limited PROM (passive range of motion) in RUE (right upper extremity).
11/3/15 - [R2] care conference was held with wife and daughters. Many concerns were discussed including RUE pain management.
11/9/15 - PROM very limited due to [R2] reporting pain and refusing.
11/16/15 - [R2] had significant pain in right hand and forearm today.
11/20/15 - [R2] complained of discomfort at times.
11/23/15 - PROM RUE with limited ROM and complaints of pain.
11/25/15 - did not verbalize pain but grimaced with movement with PROM.
11/26/15 - PROM with maximum complaints of pain, OT only able to do minimal ROM.
11/27/15 - [R2] has stiff digits and extension caused pain in RUE.
12/2/15 - Limited PROM as [R2] would not allow due to pain.
12/8/15 - noted right hand joint contracture, [R2] tolerated gentle PROM.
12/8/15 - Therapist Progress & Discharge Summary dated identified [R2] reports pain in right hand to severe on 10/29/15, pain in right hand to mild on 11/25/15 and pain in right hand to mild but demonstrated facial grimaces and verbalizations during ROM to indicate pain is moderate on 12/8/15.

Review of the medication administration records (MAR) from April 2016, to July 2016, identified R2 had an order for Tylenol 500 milligrams (mg) every 4 hours as needed (PRN) for pain. Documentation indicated R2 had received Tylenol

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2 830	Continued From page 11 500 mg once in April of 2016, 5 times in May 2016, 6 times in June 2016, and none in July 2016. Review of the nurses' notes clarified of the 12 times the PRN Tylenol was given, it had been given 3 times for an elevated temperature and 9 times for pain. Nursing notes identified on 5/24/16, R2 complained of pain "all over" and had identified a pain level of 5 of 10 (0 not pain, 10 being worst pain). On 5/26/16, R2 had "vocal complaints of pain (that hurts, ouch, stop). On 5/29/16, R2 had expressed pain "all over" and a pain level of 5. On 6/1/16, R2 complained of pain "all over" and a pain level of 4. On 6/2/16, R2 again complained of pain "all over" and rated the pain at a level 5. On 6/3/16, R2 complained of pain "all over" and rated the pain level as 5. On 6/6/16, R2 complained of pain "all over" and rated his pain level as 6. On 6/11/16, R2 had pain "all over" and rated his pain level as 4. On 6/12/16, R2 had pain "all over" and rated the pain level as 5. The Pain Management Policy revised 8/03, identified the facility pain protocol included identifying the intensity of pain using a 0-5 scale (5 as the highest amount of pain). Although this was the facility policy, staff did not consistently utilize this scale as evidenced by R2 rating his pain greater than 5. There was no documentation with the PRN Tylenol to identify what pain scale was used or the level of relief obtained with the administration of Tylenol. Further, without a pain assessment, there was no evidence of what an acceptable level of pain was for R2. In addition, it was unclear what R2's level of pain was with movement, at rest, and at rest following movement. The care plan dated 10/26/15, identified impaired mobility due to history of cerebral vascular	2 830		

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2 830	Continued From page 12	2 830		

accident with right hemiplegia and identified an approach of "assure adequate pain management." There were no interventions identified. Without a comprehensive assessment for pain, there were no individualized pain management approaches identified for R2.

On 7/20/16, at 11:10 a.m. NA-B stated, "he can't open his hand it hurts too much."

On 7/21/16, at 9:15 a.m. NA-C stated she did morning cares for R2. She stated, "we don't do ROM for him as it is too painful." She stated R2 really complained of pain when staff try to lift his right side. NA-C stated she let the nurse know if pain is more than usual. She stated the nurse was aware that it bothered him to move too fast.

On 7/21/16, at 10:08 a.m. NA-D stated, "sometimes I try to do a little ROM on him but he is usually resistive because it hurts him so I don't do it."

On 7/21/16, at 9:40 a.m. licensed practical nurse (LPN)-A stated the aides had not reported R2 stated he had pain. She stated "I think he just doesn't like anyone touching that arm."

On 7/21/16, at 11:00 a.m. registered nurse (RN)-B verified a pain assessment should have been completed on R2 and staff should have been reporting increased pain to nurse.

The Pain Management Policy revised 8/03, identified it was facility policy to assess the amount of pain a resident was experiencing and to evaluate the analgesic prescribed. The facility pain protocol included identifying the intensity of pain using a 0-5 scale (5 as the highest amount of pain), analgesic used, plan and comments and

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2 830	Continued From page 13 efficacy of pharmacological and non-pharmacological interventions. The policy also indicated an ongoing pain management plan would be addressed on the resident's care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure that all residents have their pain management needs met. The DON or designee could educate all appropriate staff on the collaboration of pain. The DON or designee could develop a monitoring systems to ensure ongoing compliance and present those findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 895	Corrected.	8/25/16

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2 895	Continued From page 14	2 895		

review the facility failed to provide range of motion (ROM) services to maximize strength and mobility for 2 of 3 residents (R33, R2) reviewed for range of motion services.
Findings include:
R33 was admitted with diagnoses which included progressive supranuclear palsy (brain disorder which affects movement), Parkinsonism, osteoporosis, diabetes, anxiety and depression.
Review of the medical record indicated R33 received physical therapy (PT) with a start of care date of 1/13/16, and end of care date of 3/2/16.
The daily treatment note dated 3/2/16, stated "Patient progress has plateaued. Patients restorative nursing program reviewed with physical therapy assistant (PTA). Nursing staff has been instructed in ROM. This program will continue under supervision of nursing staff. At this time patient continues to remain completely dependent on all cares. Patient reports that discomfort in the right upper arm has decreased to a mild level. Patient's treatment supervision discontinued (by PT). Nursing staff to continue with a maintenance range of motion program under their supervision."
PT daily treatment notes identified:
2/16/16: received passive range of motion (PROM) with end stretch bilateral upper extremities(BUE) and bilateral lower extremities (BLE) to improve ROM for wheelchair (W/C) positioning and comfort.
2/18/16: Resident reports PROM feels good. Tolerated PROM to BUE and BLE with gentle end range stretch to all joints and resident tolerance x 10 repetitions. Active ROM (AROM) to right UE at fingers, wrist, elbow and shoulder x 10 repetitions. Tolerated session well. Continue with current plan of care to increase ROM and decrease pain.
2/24/16: Patient received PROM LLE AND LUE

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2 895	Continued From page 15 and AROM RUE and RLE with end stretch. Instructed nursing assistant (NA)[-B] in PROM and AROM programs. Discussed the plan to discharge patient to a restorative nursing program on a PROM program. 2/25/16: Instructed 3 NA staff (individuals not identified), in PROM to be done twice a day (BID) once in the a.m. before getting out of bed and once in p.m. before going to bed.. Spoke with night nurse regarding program follow up. The PT discharge summary dated 3/2/16, identified: Patient/Caregiver Training: Nursing staff instructed in AROM exercises. Discharge plans and instructions: Patient will remain a resident of this extended care facility and will receive a restorative nursing program for ROM. Individualized exercise program dated 12/14/15, detailed an exercise program to be provided. A note was provided for direct care staff with the individualized program identified. Following the program a handwritten note dated 2/25/16, identified PROM BUE and BLEs BID, Morning and Evening. The individualized program directed 5 repetitions of each exercise to be completed with each session. During observation on 7/19/16, at 6:03 p.m. NA-B provided bedtime (HS) care for R33. R33 was not observed to assist with position changes or transfer from chair to toilet or bed and a stand lift was utilized. R33 did not move her left hand or arm and it remained in an elbow bent position, held against her body. NA-C came into the room and assisted with washing resident. Both NA-B and NA-C assisted with dressing R33's upper body. R33's right arm was stiff and resistant to movement. Following the provision of personal cares and dressing in night clothes, R33 was transferred from the toilet utilizing the stand up lift and was positioned on the side of the bed. R33's body position remained stiff with head forward	2 895		

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2 895	Continued From page 16	2 895		

toward her chest, and ankles pronated downward and toes pointed. Both NAs positioned R33 so she was lying on her back in the bed. Once positioned on the bed R33 was noted to have a rolled cloth in her left hand. The fingers of both hands were in a curled position. No attempt was made to remove cloth and/or wash R33's palms or under fingers. At 6:34 p.m. NA-B positioned a pillow under R33's left arm, and asked if it was alright to provide exercise at this time. R33 verbalized agreement and NA-B provided ROM to upper right arm and both lower legs performing a total of three (3) repetitions for each limb. Positioned resident for comfort, NA-B stated R33's cares were complete and this was the usual routine for personal cares and ROM. NA-B stated therapy did the ROM on R33's right arm. Licensed practical nurse (LPN)-A was interviewed on 7/20/16, at 7:55 a.m. and stated R33 required total assistance with activities of daily living (ADLs) and that she was very rigid and needed full assist. LPN-A further stated R33 was supposed to receive ROM to all extremities twice a day morning and evening. In addition LPN-A reported the decline in ADL status had been discussed at the most recent care conference on 7/18/16. It was also indicated R33 had a skin tear on the posterior surface of her left hand and this was thought to be the result of using the lift and R33's inability to grip with her left hand.

On 7/20/16, at 1:17 p.m. NA-A was interviewed and stated R33 was positioned in her bed or chair by staff and a pillow was placed under her left arm and a roll was placed into her left hand. NA-A indicted R33 received ROM exercises to her lower body but was not aware of any ROM that was supposed to be provided for the upper body.
Review of the NA flow sheet for 7/16 indicated

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2 895	Continued From page 17 R33 received ROM exercise in the PM but nothing was documented as having been provided in the AM. Review of the care plan did not identify the ROM program, but it was identified on the treatment record and flow sheet utilized by NAs to document the ROM activities Request was made for a policy addressing ROM and restorative programs, but nothing was provided. Physician orders signed 7/19/16, identified R2 was admitted to the facility on 10/14/15, with diagnoses including a cerebral vascular accident (CVA) with hemiplegia (paralysis) affecting the right side. The quarterly Minimum Data Set (MDS) dated 4/26/16, identified moderate cognitive impairment, extensive assistance needed with all activities of daily living (ADL's) and a functional limitation of upper and lower extremities. The admission Care Area Assessment (CAA) dated 10/27/15, identified R2 as having a history of a CVA (cerebral vascular accident) with right hemiplegia. Staff provided extensive to total assistance with all ADL's. R2 did not walk, transferred with a mechanical lift and received PT (physical therapy) and OT (occupational therapy) to increase strength and mobility. Review of the current nursing assistant care sheet identified R2 was receiving ROM (range of motion) everyday as tolerated, slow/gentle. A PT note dated 3/30/16, indicated a plan to discharge patient from formal physical therapy by end of this week. A PROM (passive range of motion) program was to continue for right lower extremity (RLE) and right upper extremity (RUE) as well as a strengthening program for maintenance.	2 895		

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2 895	Continued From page 18 R2 received occupational therapy (OT) from 10/15/15, to 12/8/15. Review of the OT notes identified : 10/26/15, mild to moderate contractures present in hand. A trial of a right resting splint was initiated to maintain skin integrity and prevent further contracture. 10/29/15, pt was not wearing right resting splint and significant contracture/limited prom was noted in the RUE. Pt's wife had brought in a splint R2 had from a previous hospitalization but the splint did not address finger contractures. A temporary resting splint was placed on R2's right hand. 11/2/15, a new resting splint was ordered for R2. The splint that was available at the facilty was placed temporarily on R2's right arm/hand. 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 resting 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	2 895		

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2 895	Continued From page 19	2 895		

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 protection and contracture management" This goal was identified as being met on 12/8/15.

R2 also received PT (physical therapy) from 10/15/15, to 12/7/15. Review of the PT Therapist Progress & Discharge Summary dated 12/7/15, identified that nursing staff was instructed in a maintenance range of motion program.

On 7/20/16, at 7:15 a.m. R2 was observed sitting up in wheelchair. R2 was unable to open his right hand. R2 stated it hurt if he tried to open it. No splint or palm protector was in place. Nursing assistant (NA)-A got R2 up for the day and stated staff didn't do any exercises with R2.

On 7/20/15, at 10:08 a.m. COTA-B stated OT had previously worked with R2 with ROM to the affected side to see if ROM could be improved. He stated R2's hand was not contracted at that time and R2 had reached a plateau so OT was discontinued. He also stated OT did not look at R2 for a splint program. He stated the facility did

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2 895	Continued From page 20 not have a restorative program so if nursing deemed it appropriate they could get a physician's order and evaluate R2 for PT or OT. On 7/20/16, at 11:10 a.m. NA-B stated, "he can't open his hand it hurts too much." Additionally NA-B state staff did not do exercises on R2 "At one time he had a brace but I don't know what happened to it." On 7/20/16, at 12:29 p.m. OTRL (occupational therapist registered licensed)-A stated OT worked with R2 for a splint for the right arm/hand. She stated it was passed on to nursing to set up the splint schedule in 12/15. OTRL-A observed R2 and stated his hand was not any worse (more contracted) than it was before. She thought his wife brought in a splint but they tried a different one, she did not remember if it worked for R2 or not. On 7/20/16, at 12:37 p.m. physical therapy assistant (PTA)-A stated R2 was on a maintenance program for ROM mainly for the right side to prevent contractures. She indicated that PT wrote up a program for nursing and talked to staff to make sure they were continuing with ROM to prevent contractures. She also stated, "they should be doing it daily." On 7/20/16, at 2:29 p.m. R2's wife was interviewed. She stated she never had a splint for him at home and had not brought one to the facility. However, she thought that would be a good idea. On 7/21/16, at 9:15 a.m. NA-C stated she had done morning cares for R2. "We don't do ROM for him as it is too painful."	2 895		

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2 895	Continued From page 21 On 7/21/16, at 10:08 a.m. NA-D stated, "sometimes I try to do a little ROM on him but he is usually resistive so I don't do it." On 7/21/16, at 10:30 a.m. registered nurse (RN)-A verified R2 should be receiving ROM daily as identified by the flow sheet. She stated the NA's learn ROM in NA class. RN-A further stated they usually did it 5-10 minutes. She stated the NA flow sheet should have identified where the ROM was being done. RN-A stated if R2 was refusing or staff was not completing the ROM the nurse should be notified. She was unaware that OT had recommended the use of a palm protector and stated that should have been communicated and placed on the NA flow sheets. A policy on ROM was requested but none was provided by the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review range of motion systems to ensure all residents receive appropriate services. The DON or designee could educate all appropriate staff/departments to ensure all residents are assessed for ROM needs and receive appropriate services. The director of nursing or designee, could conduct random audits of the delivery of care to ensure appropriate care and services are implemented. Results of the audits could be reviewed with the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control	21390		8/22/16

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21390	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 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 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 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 screening was completed for 6 of 6 residents (R27, R33, R44, R47, R48, R59) reviewed for infection control. Findings include:	21390	Corrected.	

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21390	Continued From page 23 1. R27 was admitted on 2/25/16 and received a 2-step TST on 2/27/16 and 3/12/16. No symptom screening was completed. 2. R33 had an admission date of 4/27/16 and received a 2-step TST on 4/29/15 and 5/13/15. No symptom screening was completed. 3. R44 had an admission date of 10/13/15 and received a 2-step TST on 10/22/15 and 11/5/15. No symptom screening was completed. 4. R47 had an admission date of 7/21/15 and received a 2-step TST on 7/23/15 and 8/6/15. No symptom screening was completed. 5. R48 was admitted on 8/12/15, received 2-step TST on 8/15/15 and 8/28/15. No symptom screening was completed. 6. R59 had an admission date of 7/12/16 and received the first of the 2-step TST on 7/14/16. No symptom screening was completed. During interview with the director of nursing (DON) on 7/20/16, at 9:53 a.m. it was verified Tuberculosis (TB) symptom screening was not being completed for new residents. It was further confirmed the only assessment being completed was the admission history form and that did not address signs and symptoms related to active TB. Registered nurse (RN)-A (infection control nurse) was interviewed on 7/20/16, at 11:25 a.m.. She indicated she was not aware of the need to complete a TB symptom screening for new admissions. Review of the admission history form with RN-A verified the screening for signs and symptoms of TB was not completed. The Baseline TB Screening Tool for Nursing Home and Boarding Care Home Residents was provided as part of the facility infection control information, and RN-A as well as the DON	21390		

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21390	Continued From page 24 verified it was not currently being utilized for admissions. The facility Tuberculosis Policy and Procedures with a review date of 10/15 indicated residents with a positive Mantoux needed a chest x-ray x 1; if chest x-rays are negative with no symptoms of TB infection, no further x-rays needed. Any resident with a positive PPD(TB test) and symptoms of active TB will be considered suspicious for TB. A physician and the DON will be notified for further direction to transfer the resident to a facility that is able to provide care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure current tuberculosis prevention and management protocols as directed by the Centers for Disease Control (CDC) and Minnesota Department of Health (MDH) are followed. The DON or designee could ensure all appropriate staff are educated. The DON or designee could develop a monitoring system to ensure ongoing compliance. The DON or designee could report monitoring results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.	21695		9/5/16

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21695	Continued From page 25 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain a clean, sanitary environment, and resident rooms in good repair, for 11 of 30 residents. Findings include: Observations noted during the initial tour on 7/18/16, and verified on 7/21/16, at 12:50 p.m. with the environmental director (ED) were as follows: 1. R1's bathroom wall was damaged, the wall bulged outward along the floor board. The wall was cracked open, and revealed a black, loose, wet, substance that was visible inside the wall. The paint and surface around the opening was moist and easily crumbled away when touched. The opening was approximately 18 inches long and gapped 4 inches. Family member (FM)-A identified that she reported the damaged wall in 4/16, but no repairs had been completed. While in the room the ED verified he was aware of the damaged wall. 2. R57's bathroom had a pungent foul urine odor. The white tiles with grout had black debris and were discolored. 3. R20's bathroom had a strong urine odor that could be detected at the entry door to the room. 4. R14's bathroom had a strong malodorous smell which seemed to concentrate by the entryway to the room. The bathroom door was noted to be heavily scraped, with missing paint and surface damage. 5. R1's bathroom had a strong urine odor. There were 1 to 2 inch holes and gouges noted on the	21695	Corrected.	

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21695	Continued From page 26 bathroom walls, especially prevalent around the sink. The door frames to the room, and to the bathroom, were heavily scraped, with paint chipped off. 6. R25's bathroom and entry door frames, were noted to be heavily scraped with black marks and revealed paint removed and surface damage. 7. R13's room revealed holes in the wall, that were in need of repair. The walls in the room were marked with black marks. The entry and bathroom door frames, were marked with black marks and the surface was heavily scraped and damaged. 8. R45's wall on the left side of the window, had a 2 inch gouge to the sheet rock, the paint and surface was heavily scraped. 9. R39's ceiling tile was cracked completely across the tile. 10. R41's wall behind her chair was damaged covering an area 4 x 3 feet. The surface was bubbled, and when touched was full of moisture, which crumbled. The paint was releasing from moisture. 11. R38's walls revealed holes, black marking, severe scrapes, and paint missing. The resident stated that they have been there since she moved in a year ago. The corners of the bathroom had a build up of debris, and the grout was stained, brown and yellow and crumbled away when touched. The bathroom and entry door frames, were stained, had black marks, and were heavily scraped with surface damage. 12. The lower 3 feet of the dining room walls were heavily scraped, black marks were evident, and paint was missing. Sections of wall paper were surface damaged, and releasing from the wall revealing the sheet rock underneath. The Plexiglass walls surrounding the coffee serving area were stained, and the surface was scraped, and surface damaged.	21695		

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21695	Continued From page 27 During the tour the ED stated at 1:30 p.m. he had a quarterly schedule to make the necessary environmental repairs (e.g.. walls, floors, tile). However upon request he was unable to submit any such schedule. The ED stated the housekeeping staff cleaned each room and bathroom daily. He was unsure why the odors existed, and turned on three bathroom exhaust fans during the tour. The ED stated the housekeepers were responsible to report when repairs were needed. When in the west wing the ED presented a clip board that was used for communication, when there were environmental issues in need of repair. There were no notes on the communication board. Review of the policy dated as revised 1/15, Housekeeping Infection Control Guidelines included patient bathroom wall tile was scrubbed every six months with disinfectant. The policy dated as revised 1/14, titled Building Maintenance Policy identified routine building maintenance was to be performed daily by the maintenance staff, with input from other departments utilizing the repair sheets located in the South Wing and one on the East Wing. Staff nurses were instructed to contact maintenance staff immediately if something needed to be repaired sooner. On a semi-annual basis, coinciding with the housekeeping department's waxing of resident room floors, maintenance staff went through the rooms to repair any items in need of touch up. The checklist included: paint, windows, doors, cabinets, closets and walls (nails, paint, and wallpaper). SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00682	A. BUILDING: _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE INN NURSING HOME	108 8TH STREET NORTHWEST WASECA, MN 56093

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21695	Continued From page 28 ensure all resident areas are kept in good repair. The administrator or designee could educate all appropriate staff on the policies and procedures for reporting of damage or need for repair. The administrator or designee could develop monitoring systems to ensure ongoing compliance. Results of these monitoring/audits could be reviewed at the quarterly quality assurance meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		