

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GY35

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00773

1. MEDICARE/MEDICAID PROVIDER NO. (L1) <b>245533</b>  2.STATE VENDOR OR MEDICAID NO. (L2) <b>314182000</b>  5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)  6. DATE OF SURVEY <b>12/072021</b> (L34)  8. ACCREDITATION STATUS: ___ (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other	3. NAME AND ADDRESS OF FACILITY (L3) <b>LAKESIDE GENERATIONS</b> (L4) <b>439 WILLIAM AVENUE EAST, PO BOX 383</b> (L5) <b>DASSEL, MN</b> (L6) <b>55325</b>  7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) <b>01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA</b> <b>02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF</b> <b>03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC</b> <b>04 SNF 08 OPT/SP 12 RHC 16 HOSPICE</b>	4. TYPE OF ACTION: <u>7</u> (L8)  <b>1. Initial 2. Recertification</b> <b>3. Termination 4. CHOW</b> <b>5. Validation 6. Complaint</b> <b>7. On-Site Visit 9. Other</b>  <b>8. Full Survey After Complaint</b>  FISCAL YEAR ENDING DATE: (L35)  <b>09/30</b>															
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :  12.Total Facility Beds <b>54</b> (L18) 13.Total Certified Beds <b>54</b> (L17)	10.THE FACILITY IS CERTIFIED AS: <b>X</b> A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements Compliance Based On: ___ 1. Acceptable POC ___ 2. Technical Personnel ___ 6. Scope of Services Limit ___ 3. 24 Hour RN ___ 7. Medical Director ___ 4. 7-Day RN (Rural SNF) ___ 8. Patient Room Size ___ 5. Life Safety Code ___ 9. Beds/Room  B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: <b>A</b> (L12)																
14. LTC CERTIFIED BED BREAKDOWN  <table style="width:100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">18 SNF</td> <td style="text-align: center;">18/19 SNF</td> <td style="text-align: center;">19 SNF</td> <td style="text-align: center;">ICF</td> <td style="text-align: center;">IID</td> </tr> <tr> <td></td> <td style="text-align: center;">54</td> <td></td> <td></td> <td></td> </tr> <tr> <td style="text-align: center;">(L37)</td> <td style="text-align: center;">(L38)</td> <td style="text-align: center;">(L39)</td> <td style="text-align: center;">(L42)</td> <td style="text-align: center;">(L43)</td> </tr> </table>	18 SNF	18/19 SNF	19 SNF	ICF	IID		54				(L37)	(L38)	(L39)	(L42)	(L43)	15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)	
18 SNF	18/19 SNF	19 SNF	ICF	IID													
	54																
(L37)	(L38)	(L39)	(L42)	(L43)													

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

17. SURVEYOR SIGNATURE  Date :  <u>Kimberly Swenson SFM</u> 01/08/2022 (L19)	18. STATE SURVEY AGENCY APPROVAL  Date:  <u>Joanne Simon, Enforcement Specialist</u> 01/08/2022 (L20)
--	---

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

19. DETERMINATION OF ELIGIBILITY  <input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 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 <b>01/24/1989</b> (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) <u>VOLUNTARY</u> <b>00</b> 01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal  <u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety 06-Fail to Meet Agreement  <u>OTHER</u> 07-Provider Status Change 00-Active		
28. TERMINATION DATE:  29. INTERMEDIARY/CARRIER NO. <b>03001</b> (L28) (L31)	30. REMARKS  DETERMINATION APPROVAL	
31. RO RECEIPT OF CMS-1539 (L32)	32. DETERMINATION OF APPROVAL DATE <b>01/11/2022</b> (L33)	



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

Electronically delivered  
January 28, 2022

CMS Certification Number (CCN): 245533

Administrator  
Lakeside Generations  
439 William Avenue East, Po Box 383  
Dassel, MN 55325

Dear Administrator:

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 December 6, 2021 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Enforcement Specialist  
Minnesota Department of Health  
Program Assurance Unit  
Health Regulation Division  
Telephone: 651-201-4161 Fax: 651-215-9697  
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



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

Electronically Delivered  
January 28, 2022

Administrator  
Lakeside Generations  
439 William Avenue East, Po Box 383  
Dassel, MN 55325

RE: CCN: 245533  
Cycle Start Date: October 27, 2021

Dear Administrator:

On December 7, 2021, the Minnesota Department Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink, appearing to read 'Joanne Simon', with a horizontal line extending to the right.

Joanne Simon, Enforcement Specialist  
Minnesota Department of Health  
Program Assurance Unit  
Health Regulation Division  
Telephone: 651-201-4161 Fax: 651-215-9697  
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File





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

Electronically delivered  
November 17, 2021

Administrator  
Lakeside Generations  
439 William Avenue East, Po Box 383  
Dassel, MN 55325

RE: CCN: 245533  
Cycle Start Date: September 27, 2021

Dear Administrator:

On October 27, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

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

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

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

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

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

## DEPARTMENT CONTACT

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

**Judy Loecken, Unit Supervisor**  
**St. Cloud B District Office**  
**Licensing and Certification Program**  
**Health Regulation Division**  
**Minnesota Department of Health**  
**Midtown Square**  
**3333 Division Street, Suite 212**  
**Saint Cloud, Minnesota 56301-4557**  
**Email: judy.loecken@state.mn.us**  
**Office: (320) 223-7300 Mobile: (320) 241-7797**

## PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

## VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by January 27, 2022 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by April 27, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: [https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\\_8.html](https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html)

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

Lakeside Generations

November 17, 2021

Page 4

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

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

Feel free to contact me if you have questions.

Sincerely,



Joanne Simon, Enforcement Specialist  
Minnesota Department of Health  
Program Assurance Unit  
Health Regulation Division  
Telephone: 651-201-4161 Fax: 651-215-9697  
Email: [joanne.simon@state.mn.us](mailto:joanne.simon@state.mn.us)

cc: Licensing and Certification File



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245533</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>10/27/2021</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKESIDE GENERATIONS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>439 WILLIAM AVENUE EAST, PO BOX 383 DASSEL, MN 55325</b>
---	--

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <b>Electronically Signed</b>	TITLE	(X6) DATE <b>11/22/2021</b>
---	-------	--------------------------------

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.

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

PRINTED: 12/06/2021  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245533</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/27/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKESIDE GENERATIONS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>439 WILLIAM AVENUE EAST, PO BOX 383 DASSEL, MN 55325</b>		
(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	<p>Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR</p> <p>By email to: FM.HC.Inspections@state.mn.us</p> <p>THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:</p> <ol style="list-style-type: none"> <li>1. A detailed description of the corrective action taken or planned to correct the deficiency.</li> <li>2. Address the measures that will be put in place to ensure the deficiency does not reoccur.</li> <li>3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.</li> <li>4. Identify who is responsible for the corrective actions and monitoring of compliance.</li> <li>5. The actual or proposed date for completion of the remedy.</li> </ol> <p>Lakeside Health Care Center is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1978, an addition was constructed and was determined to be of Type II(111) construction. In 1984, an addition was constructed and was determined to be of Type II(111) construction. The most recent addition was constructed in 1993 and was determined to be of Type II(111) construction.</p>	K 000			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245533</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/27/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKESIDE GENERATIONS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>439 WILLIAM AVENUE EAST, PO BOX 383 DASSEL, MN 55325</b>		
(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	Continued From page 2 Because the original building and the 3 additions met 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.  The facility has a capacity of 54 beds and had a census of 42 at the time of the survey.	K 000			
K 353 SS=F	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Sprinkler System - Maintenance and Testing CFR(s): NFPA 101  Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____  Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system.	K 353		12/6/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245533</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/27/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKESIDE GENERATIONS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>439 WILLIAM AVENUE EAST, PO BOX 383 DASSEL, MN 55325</b>		
(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 353	Continued From page 3 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, 9.7.7, and 9.7.8, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2 and 5.3.2.1. The Standard for Testing and Maintenance of Sprinkler Systems. This deficient finding could have a widespread impact on the residents within the facility.  Findings include:  On 10/27/2021 at 9:45 AM, it was revealed by observation the last 5-year inspection and gauge replacement or recalibrating was completed on 04/03/2016.  An interview with Maintenance Tech (SC) verified this deficient finding at the time of discovery.	K 353	K353 SS=F  It is the practice of this facility to have the automatic sprinkler and standpipe systems be inspected, tested, and maintained in accordance with NFPA 25. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available which needs to be tested every 5 years. All residents have the potential, to be affected, however there was no actual harm. Maintenance Supervisor and or designee will be re-educated by Administrator and or designee on frequency of the testing of the Water Based Fire Protection System. The work order was added to Maintenance Care and electronic work order system to be conducted every 5 years. On November 29th 2021 Brothers Fire and Security have been scheduled to test the sprinkler system. Completion date 12/06/2021		
K 712 SS=F	Fire Drills CFR(s): NFPA 101  Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of	K 712		12/6/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>245533</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>10/27/2021</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAKESIDE GENERATIONS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>439 WILLIAM AVENUE EAST, PO BOX 383 DASSEL, MN 55325</b>		
(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 712	<p>Continued From page 4</p> <p>established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms.</p> <p>19.7.1.4 through 19.7.1.7</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on a review of available documentation and staff interview, the facility failed to conduct fire drills per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.4. This deficient finding could have a widespread impact on the residents within the facility.</p> <p>Findings include:</p> <p>On 10/27/2021 at 10:15 AM, it was revealed by a review of available documentation the facility did not document the integrity of the alarm transmission during 6 of the last 12 months.</p> <p>An interview with Maintenance Tech (SC) verified this deficient finding at the time of discovery.</p>	K 712	<p>K712 SS=F</p> <p>It is the practice of this facility to hold fire drills at unexpected times under varying conditions, at least quarterly on each shift. All residents and visitors have the potential to be affected, however there was no actual harm. Maintenance Supervisor or designee will be re-educated by Administrator and or designee on documentation of the integrity of the alarm transmission. These fire drills will be monitored and taken to the monthly safety committee for the next 6 months.</p> <p>Completion date 12/06/21</p>		