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

**MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL**

ID: LIRD

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00594

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245215**

2.STATE VENDOR OR MEDICAID NO.
(L2) **001043000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKESHORE INC**
(L4) **4002 LONDON ROAD**
(L5) **DULUTH, MN** (L6) **55804**

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 **09/04/2014** (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)
**06/30**

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

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (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 |
|---|---|---|---|---|
| | 60 | | | |
| (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):

**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Cheryl Johnson, HFE NEII 09/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 10/16/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
**X** 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
**07/01/1977**
(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
Posted 10/30/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
**08/13/2014**
(L33)

DETERMINATION APPROVAL

**C&T REMARKS - CMS 1539 FORM** **STATE AGENCY REMARKS**

CCN: 24 5215

On September 4, 2014, the Minnesota Department of Health completed a Post Certification Revisit PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 12, 2014 and an FMS complete on July 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 26, 2014.

Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 12, 2014 and our FMS completed on July 17, 2014, effective August 26, 2014.

As a result of the September 4, 2014 revisit, this Department recommended to the CMS Region V office the following action related to the remedy in their letter of July 25, 2014:

Mandatory Denial of Payment for new Medicare and Medicaid Admissions, effective September 12, 2014, be rescinded.

This would also rescind NATCEP loss since the primary trigger never went into effect.

Refer to the CMS 2567b forms for the results of this visit.

Effective August 26, 2014, the facility is certified for 60 skilled nursing facility beds.

*Protecting, Maintaining and Improving the Health of Minnesotans*

CMS Certification Number (CCN): 245215

September 25, 2014

Mr. John Korzendorfer, Administrator
Lakeshore Inc
4002 London Road
Duluth, Minnesota 55804

Dear Mr. Korzendorfer:

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 August 26, 2014 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 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.

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
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically delivered
September 25, 2014

Mr. John Korzendorfer, Administrator
Lakeshore Inc
4002 London Road
Duluth, Minnesota 55804

RE: Project Number S5215025, S5215027

Dear Mr. Korzendorfer:

On June 23, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 12, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On July 17, 2014, a survey team representing the office of the Centers for Medicare and Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the survey team informed you during the exit conference. The FMS revealed that your facility continues to not be in substantial compliance. the FMS found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 25, 2014, CMS notified you of the results of the FMS and that your facility continues to not be in substantial compliance. Therefore CMS imposed the following remedy:

- Mandatory Denial of Payment for new Medicare and Medicaid Admissions, effective September 12, 2014

In addition, CMS notified you in their letter of July 25, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 12, 2014.

On September 4, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 12, 2014 and an FMS complete on July 17, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 26, 2014.

Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 12, 2014 and our FMS completed on July 17, 2014, effective August 26, 2014.

As a result of the September 4, 2014 revisit, this Department recommended to the CMS Region V office the following action related to the remedy in their letter of July 25, 2014:

- Mandatory Denial of Payment for new Medicare and Medicaid Admissions, effective September 12, 2014, be rescinded

In addition, CMS advised you in their letter of July 25, 2014 that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 12, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 26, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5215r14LC&FMS

**Department of Health and Human Services**
**Centers for Medicare & Medicaid Services**

Form Approved
OMB NO. 0938-0390

## Post-Certification Revisit Report



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245215 | A. Building<br>B. Wing | 9/4/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| LAKESHORE INC | 4002 LONDON ROAD<br>DULUTH, MN 55804 |

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).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **F0156**<br>Reg. # **483.10(b)(5) - (10), 483.10(b)(1)**<br>LSC | Correction Completed **07/21/2014** | ID Prefix **F0176**<br>Reg. # **483.10(n)**<br>LSC | Correction Completed **07/21/2014** | ID Prefix **F0282**<br>Reg. # **483.20(k)(3)(ii)**<br>LSC | Correction Completed **07/21/2014** |
| ID Prefix **F0314**<br>Reg. # **483.25(c)**<br>LSC | Correction Completed **07/21/2014** | ID Prefix **F0329**<br>Reg. # **483.25(l)**<br>LSC | Correction Completed **07/21/2014** | ID Prefix **F0332**<br>Reg. # **483.25(m)(1)**<br>LSC | Correction Completed **07/21/2014** |
| ID Prefix **F0441**<br>Reg. # **483.65**<br>LSC | Correction Completed **07/21/2014** | ID Prefix **F0465**<br>Reg. # **483.70(h)**<br>LSC | Correction Completed **07/21/2014** | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | PLH/mm | 09/25/2014 | 25479 | 09/04/2014 |
| Reviewed By<br>CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 6/12/2014 | | | |

**Department of Health and Human Services**
**Centers for Medicare & Medicaid Services**

Form Approved
OMB NO. 0938-0390

**Post-Certification Revisit Report**



| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 245215 | A. Building<br>B. Wing | 9/4/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| LAKESHORE INC | 4002 LONDON ROAD<br>DULUTH, MN 55804 |

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).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **F0279**<br>Reg. # **483.20(d), 483.20(k)(1)**<br>LSC | Correction Completed **08/26/2014** | ID Prefix **F0280**<br>Reg. # **483.20(d)(3), 483.10(k)(2)**<br>LSC | Correction Completed **08/26/2014** | ID Prefix **F0282**<br>Reg. # **483.20(k)(3)(ii)**<br>LSC | Correction Completed **08/26/2014** |
| ID Prefix **F0309**<br>Reg. # **483.25**<br>LSC | Correction Completed **08/26/2014** | ID Prefix **F0431**<br>Reg. # **483.60(b), (d), (e)**<br>LSC | Correction Completed **08/26/2014** | ID Prefix **F0441**<br>Reg. # **483.65**<br>LSC | Correction Completed **08/26/2014** |
| ID Prefix **F0502**<br>Reg. # **483.75(j)(1)**<br>LSC | Correction Completed **08/26/2014** | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| State Agency | PLH/mm | 09/25/2014 | 25479 | 09/04/2014 |
| Reviewed By<br>CMS RO | Reviewed By | Date: | Signature of Surveyor: | Date: |

| Followup to Survey Completed on: | Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? | YES | NO |
|---|---|---|---|
| 7/17/2014 | | | |

*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically delivered

September 25, 2014

Mr. John Korzendorfer, Administrator
Lakeshore Inc
4002 London Road
Duluth, Minnesota 55804

Re: Reinspection Results - Project Number S5215025

Dear Mr. Korzendorfer:

On September 4, 2014 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 June 12, 2014. 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.

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
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245215

July 25, 2014
By Certified Mail and Facsimile

Mr. John Korzendorfer, Administrator
Lakeshore, Inc.
4002 London Road
Duluth, MN 55804

Dear Mr. Korzendorfer:

**SUBJECT: FEDERAL MONITORING SURVEY RESULTS AND NOTICE OF IMPOSITION OF REMEDY**
**Cycle Start Date: June 12, 2014**

**STATE SURVEY RESULTS**
On June 10, 2014, a Life Safety Code survey and on June 12, 2014, a health survey were completed at Lakeshore, Inc. by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys found that your facility was not in substantial compliance, with the most serious deficiency at scope and severity (S/S) level F, cited as follows:

- F441 -- S/S: F -- 483.65 -- Infection Control, Prevent Spread, Linens.

The State agency advised you of the deficiency that led to this determination and provided you with a copy of the survey report (CMS-2567).

**FEDERAL MONITORING SURVEY**
In its notice dated June 23, 2014, the MDH informed you that your facility could avoid the imposition of remedies if substantial compliance was achieved by July 22, 2014. Before a revisit was conducted, however, a survey team representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on July 17, 2014. As the survey team informed you during the exit conference, the FMS revealed that your facility continues to not be in substantial compliance. The FMS found additional deficiencies, with the most serious being at S/S level E, cited as follows

- F431 -- S/S: E -- 483.60(b), (d), (e) -- Drug Records Label/Store Drugs & Biologicals

The findings from the FMS are sent electronically through the ASPEN system. Enclosed is a list of the "resident identifiers" used in writing the Statement of Deficiencies. The "resident identifiers" will enable you to identify any specific residents referred to in the CMS-2567.

**ELECTRONIC PLAN OF CORRECTION (ePOC)**

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the enclosed deficiencies cited at the FMS. 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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation.

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; and
- An electronic acknowledgement signature and date by an official facility representative.

**INFORMAL DISPUTE RESOLUTION**

The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visit. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an IDR process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR 488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing to Stephen Pelinski, Branch Manager, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your ePOC. You must provide an acceptable ePOC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

**SUMMARY OF ENFORCEMENT REMEDIES**
As a result of the survey findings, we are imposing the following remedy:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective September 12, 2014

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

**DENIAL OF PAYMENT FOR NEW ADMISSIONS**
Mandatory denial of payment for all new Medicare admissions is imposed effective September 12, 2014 if your facility does not achieve compliance within the required three months. This action is mandated by the Social Security Act at Sections 1819(h)(2)(D) and 1919 (h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). We are notifying National Government Services that the denial of payment for all new Medicare admissions is effective on September 12, 2014. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective September 12, 2014.

You should notify all Medicare and Medicaid residents admitted on or after this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new Medicare admissions includes Medicare beneficiaries enrolled in managed care plans. It is your obligation to inform Medicare managed care plans contracting with your facility of this denial of payment for new admissions.

**TERMINATION PROVISION**
If your facility has not attained substantial compliance by December 12, 2014, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR Section 489.57 will apply.

**NURSE AIDE TRAINING PROHIBITION**

Please note that Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000.00; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 12, 2014, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Lakeshore, Inc. will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 12, 2014. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

**APPEAL RIGHTS**

This formal notice imposed:

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective September 12, 2014

If you disagree with the finding of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. seq. **A <u>written</u> request for a hearing must be filed <u>no later than 60 days</u> from the date of receipt of this notice.** Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

**It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki.**

A request for a hearing should identify the specific issues and the findings of fact and

conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The DAB will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing. Counsel may represent you at a hearing at your own expense.

**CONTACT INFORMATION**

If you have any questions regarding the Federal Monitoring Survey, please contact Sharon White, RN, MN State Leader, at (312) 353-7166. For questions regarding this enforcement case, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443)380-6602. All correspondence should be directed to Jan Suzuki in our Chicago office.

Sincerely,

Gregg Brandush
Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Sample Resident List

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health

# State Form: Revisit Report

| (Y1) Provider / Supplier / CLIA / Identification Number | (Y2) Multiple Construction | (Y3) Date of Revisit |
|---|---|---|
| 00594 | A. Building<br>B. Wing | 9/4/2014 |

| Name of Facility | Street Address, City, State, Zip Code |
|---|---|
| LAKESHORE INC | 4002 LONDON ROAD<br>DULUTH, MN 55804 |

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).

| (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date | (Y4) Item | (Y5) Date |
|---|---|---|---|---|---|
| ID Prefix **20565**<br>Reg. # **MN Rule 4658.0405 Subp. 3**<br>LSC | Correction Completed **07/21/2014** | ID Prefix **20900**<br>Reg. # **MN Rule 4658.0525 Subp. 3**<br>LSC | Correction Completed **07/21/2014** | ID Prefix **21390**<br>Reg. # **MN Rule 4658.0800 Subp. 4 A-I**<br>LSC | Correction Completed **07/21/2014** |
| ID Prefix **21540**<br>Reg. # **MN Rule 4658.1315 Subp. 2**<br>LSC | Correction Completed **07/21/2014** | ID Prefix **21545**<br>Reg. # **MN Rule 4658.1320 A.B.C**<br>LSC | Correction Completed **07/21/2014** | ID Prefix **21565**<br>Reg. # **MN Rule 4658.1325 Subp. 4**<br>LSC | Correction Completed **07/21/2014** |
| ID Prefix **21800**<br>Reg. # **MN St. Statute144.651 Subd. 4**<br>LSC | Correction Completed **07/21/2014** | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |
| ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed | ID Prefix<br>Reg. #<br>LSC | Correction Completed |

| Reviewed By (State Agency) | Reviewed By | Date: | Signature of Surveyor: | Date: |
|---|---|---|---|---|
| | PLH/mm | 09/25/14 | 25479 | 09/04/2014 |
| **Reviewed By (CMS RO)** | **Reviewed By** | **Date:** | **Signature of Surveyor:** | **Date:** |
| | | | | |

**Followup to Survey Completed on:** 6/12/2014

**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: LIRD

**PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY**

Facility ID: 00594

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245215**

2.STATE VENDOR OR MEDICAID NO.
(L2) **001043000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKESHORE INC**
(L4) **4002 LONDON ROAD**
(L5) **DULUTH, MN** (L6) **55804**

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 **06/12/2014** (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 IMR | 15 ASC | |
| 04 SNF | 08 OPT/SP | 12 RHC | 16 HOSPICE | |

FISCAL YEAR ENDING DATE: (L35)
**06/30**

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

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

**X** B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

| 18 SNF | 18/19 SNF | 19 SNF | ICF | IMR |
|---|---|---|---|---|
| | 60 | | | |
| (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):

**See Attached Remarks**

17. SURVEYOR SIGNATURE Date :
Ann Hyrkas, HFE NEII 07/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 08/11/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
**X** 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
**07/01/1977**
(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
Posted 08/13/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically delivered
June 23, 2014

Mr. John Korzendorfer, Administrator
Lakeshore Inc
4002 London Road
Duluth, Minnesota 55804

RE: Project Number S5215025

Dear Mr. Korzendorfer:

On June 12, 2014, 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 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the June 12, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

**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**

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

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

**DEPARTMENT CONTACT**

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

**Patricia Halverson, Supervisor**
**Duluth Survey Team**
**Licensing and Certification Program**
**Division of Compliance Monitoring**
**Minnesota Department of Health**
**Email: Patricia.halverson@state.mn.us**

**Phone: (218) 302-6151**
**Fax: (218) 340-6623**

**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 July 22, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

**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.

The state agency may, in lieu of a 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:

- 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. 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 may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) 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 September 12, 2014 (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 December 12, 2014 (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
Division of Compliance Monitoring
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.

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
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-969

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245215 | A. BUILDING _____ B. WING _____ | 06/12/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKESHORE INC** | **4002 LONDON ROAD DULUTH, MN 55804** |

| (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<br><br>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.<br><br>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 156 SS=D | Census 50<br>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES<br><br>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.<br><br>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing | F 156 | | 7/21/14 |

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

Electronically Signed | 07/01/2014

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 156 | Continued From page 1 | F 156 | | |

facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 156 | Continued From page 2<br>advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.<br><br>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.<br><br>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) upon termination of all Medicare Part A skilled services for 1 of 3 residents (R286) reviewed for liability notice and beneficiary appeal rights.<br><br>Findings include:<br><br>R286 was discharged from Medicare Part A on 3/25/14, and remained in the facility until she discharged on 4/3/14. The facility did not provide R286 and/or her legal representative with a SNFABN/Centers for Medicare and Medicaid | F 156 | F156 D (Also MN Statute 21800)<br><br>1. Corrective Action:<br>Patient 286 received the appropriate Medicare notifications.<br>2. Corrective Action as it<br>Applies to other Patients: All patients have the potential to be affected by this deficient practice.<br><br>A. Starting 6/16/14 will issue SNFABN along with the Notice of Medicare Non-Coverage to every Resident who has been decided that Medicare coverage will end, and on every resident who we | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 156 | Continued From page 3<br>Services (CMS)-10055 to inform her of potential liability for non-covered services and of her right to appeal the denial to Medicare until 4/1/14.<br><br>During an interview on 6/11/14, at 2:00 p.m. the business office manager (BOM) confirmed that she had not provided R286 the SNFABN until 4/1/14. The BOM stated she was not informed when R286 did not discharge from the facility as scheduled and she issued the SNFABN as soon as she realized R286 had remained in facility.<br><br>The facility policy/procedures related to SNF DETERMINATION ON CONTINUED STAY was requested but not provided. | F 156 | anticipate to Discharge at least 48 hours in advance.<br>B. The Policy for Medicare Non-Coverage Notification was reviewed and revised as appropriate.<br>C. The Business Office Manager completed a training session on 6/16/14 with the Nurse Managers who give the Medicare Notice of Denial letters, to instruct them on giving the two Medicare Denial letters together.<br>D. The Business Office Manager completed a training session on 6/16/14 with the Nurse Managers and Social Services on documentation. All documentation pertaining to Medicare coverage will be documented in the progress notes under the Medicare/Insurance tab. Also included in this training session was a section on the importance of documenting Patient Initiated Discharges, cancelled or delayed discharges. Documentation will include discharge plan of plan of continued stay.<br><br>3. Date of Completion: July 21, 2014.<br><br>4. Reoccurrence will be Prevented by:<br>A. Staff education provided on 6/16/14.<br>B. Random audits will be conducted two times weekly for two weeks, then weekly for one month and monthly for one quarter. Findings will be reported to the QAPI team for review and discussion.<br><br>5. The Correction will be Monitored by:<br>A. The Business Office Manager or Director of Nursing or their Designee.<br>B. The QAPI Committee will review the | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|---|---|---|
| F 156 | Continued From page 4 | F 156 | audit results on a monthly basis and provide further direction, as needed. The QAPI Team will determine when the audits may be discontinued. | |
| F 176 SS=E | 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE<br><br>An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to assess safety for self administration of medications for 4 of 4 residents reviewed (R365, R81, R83, R10) observed for self administration of medications.<br><br>R364's Order Summary Report printed 6/11/4, indicated admission on 5/29/14, with diagnoses that included dementia, diabetes, and end stage renal disease. Physicians orders included Flonase Suspension 50 mcg/act (micrograms/actuation) 2 puff in both nostrils in the morning and Prednisolone Acetate Suspension 1% instill one drop in left eye four times a day for eye care. The Order Summary Report did not indicate that R365 was appropriate for self administration of medications.<br>During observation of the medication pass on 6/10/14 at 7:20 a.m. R364 was provided Flonase suspension nasal spray and was able to self administer the nasal spray. Registered nurse (RN)-E gave R364 a vial of Prednisolone eye drops to self administer. R364 took the eye drops, | F 176 | F176 D (also MN Statute 21565)<br>1. Corrective Action:<br>A. Patients 81 and 83 have discharged. Patients 365 and 10 have been re-assessed for their ability to Self Administer Medications. Their care plans have been updated.<br><br>2. Corrective Action as it applies to Other Patients: All patients have the potential to be affected by this deficient practice.<br>A. The policy and procedure for Self Administration has been reviewed and revised as appropriate.<br>B. The Self Administration of Medication Policy will be reviewed with all nursing staff at the Nursing Meeting which will be held on:_July 7, 8, 9, 11, 12, 14, and 15 2014.<br>C. All other patients will be evaluated for their ability to Self Administer Medications and new Assessments will be completed | 7/21/14 |

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| F 176 | Continued From page 5<br>put the medication up her left nostril and attempted to plug her right nostril. RN-E told R364 the eye drops didn't go there and that she would help R364. RN-E then assisted R364 with 3 additional eye medications.<br>R364's care plan initiated 6/8/14 indicated R364 had impaired cognitive function and did not direct self administration of medications.<br>When interviewed on 6/10/14 at 11:45 a.m. RN-E stated that, during the previous weekend, R364 described and demonstrated how to administer the inhaler and eye drops.<br><br>Interview with RN-C on 6/10/14, at 1:15 p.m. verified that R364 was not appropriate to self administer medications (SAM) due to her dementia. RN-C further verified there was no physician order or care plan in place as she was inappropriate for SAM. RN-C indicated R364 did not have a SAM assessment, but she was not appropriate to SAM due to her cognitive impairments. On 6/10/14 at 1:40 p.m. the director of nursing verified that residents should have assessments indicating a resident's ability to SAM. A physician's order and care plan should be developed pending the results of the assessment.<br><br>The undated facility policy for self administration of medications confirmed that only resident's assessed as safe to do so were permitted to do so by the interdisciplinary team, which included the processes of assessment, physician order, and care planning.<br><br>R81 was not assessed to be safe to self-administer inhaled medications.<br><br>On 6/11/14, at 7:12 a.m. R81 was observed in the room, seated in the wheelchair with a nebulizer | F 176 | as necessary. Care plans will be updated to reflect the patient□s ability to Self Administer Medications as appropriate.<br><br>3. Date of Completion:<br>July 21, 2014<br><br>4. Reoccurrence will be Prevented by:<br>A. DON or designee will complete random audits daily for two weeks, then weekly for one month, then monthly for one quarter.<br><br>5. The Correction will be Monitored by:<br>A. DON or designee.<br>B. The QAPI Committee will review the audit results on a monthly basis and provide further direction, as needed. The QAPI Team will determine when the audits may be discontinued. | |

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| F 176 | Continued From page 6 | F 176 | | |

treatment currently being administered. LPN-B was observed to be in the hallway outside of R81's room, preparing for a medication pass. LPN-B was observed to enter R81's neighbor's room to administer medications and then returned to the medication cart. At 7:20 a.m. LPN-B was observed to enter R81's room to provide cares to R81's lower legs. R83's nebulizer mask was still in place over R81's mouth and nose.

An Order Summary Report dated 5/30/14, indicated R81's diagnoses included COPD [chronic obstructive pulmonary disease] and was to receive DuoNeb Solution 0.5-2.5 mg/3ml 1 inhalation orally four times a day for COPD.

R81's admission Minimum Data Set (MDS) dated 5/15/14, indicated R81 was cognitively intact.

R81's self-Administration of Medication Assessment dated 5/8/14, indicated R81 was sate to self-administer all oral medication after nursing set up. A Patient Inform Fax upon Admission dated 5/8/14, indicated R81 was OK to self-administer oral medication after nursing set up. R81's Plan of Care (POC) dated 5/8/14, indicated R81 was OK to SAM after nursing set up.

On 6/11/14, at 2:10 p.m. LPN-A stated a SAM for oral medications would include all medications, solid or liquid form that are swallowed and a separate SAM order would be obtained for inhaled medications.

On 6/11/14 at 2:20 p.m. registered nurse (RN)-A confirmed a SAM order for oral medications would mean pills and nebulized/inhaled

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medications would be a separate SAM. RN-A verified R81 had a SAM order for oral medications but not for the nebulized medications.

On 6/12/14, at 8:24 a.m. the DON stated the residents should have a separate SAM order for oral or swallowed medications and for nebulzied/inhaled medications.

R83 was not observed during self administration of medication despite being assessed as unsafe to self-administer any medications. In addition, R83 had a physician's order to watch R83 take all medications.

On 6/10/14, at 10:17 a.m. during an initial interview with R83, registered nurse (RN)-B was observed to enter R83's room carrying a clear medication cup containing 1 white tablet. RN-B was heard to tell R83 the medication was a pain pill and asked R83 what level the pain was at. R83 replied the pain was at a level 6. RN-B was observed to hand the clear medication cup to R83 and then RN-B promptly left R83's room, closing the room door. R83 was observed to reach for a small, clear water pitcher containing water and a lemon slice, and then R83 placed the 1 white tablet in the mouth and drank from the water pitcher, swallowing the medication. R83's family member was noted to be sitting in the room with R83.

A computer-generated Diagnosis Report dated 6/12/14, indicated R83's diagnoses included diabetes type 2 and dementia.

R83's admission Minimum Data Set (MDS) dated 5/23/14, indicated R83 was cognitively intact, was

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receiving scheduled and as needed pain medication, and was in pain almost constantly.

A Self-Administration of Medication Assessment dated 5/18/14, indicated R83 was assessed to not be able to safely self-administer all oral medication and directed the nurse to administer medications.

An Order Summary Report dated 5/16/14, directed nursing to administer medication every shift. The Order Summary Report dated 5/30/14, directed nursing to "watch pt [patient] take pills every shift."

An Order Summary Report dated 5/28/14, directed Oxycodone [a narcotic pain medication] 5 mg by mouth 3 times per day at 6am, 10am, and 2 am.

On 6/11/14, at 2:10 p.m. licensed practical nurse (LPN)-A stated when a physician's order directs staff to watch the resident take the pills, it means to stay at the bedside and make sure the resident swallows the medications. LPN-A further stated if the physician wrote such an order, there was a reason why observation was required.

On 6/11/14, at 2:20 p.m. registered nurse (RN)-A confirmed R83's physician had written the order to make sure R83 actually swallows the medications.

On 6/12/14, at 8:24 a.m the director of nursing (DON) stated if a resident is not assessed to be safe to self-administer medications, the nurse should stay with the resident and make sure all medications are taken and swallowed before leaving the resident's room. The DON confirmed

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| F 176 | Continued From page 9<br>R83 was not assessed to be safe to self-administer medications.<br><br>On 6/10/14, at 7:00 a.m. R10 was observed to have a Flonase inhaler (for COPD) at bedside on the overbed table. The RN-E picked up the inhaler, the medication was verified, and gave it to R10 to self administer. R10 administered two puffs himself.<br><br>R10's diagnoses on the order summary report dated 6/11/14, included COPD. The medication orders included two nebulizer treatments with a specific order that stated it was OK for R10 to self administer the nebulizer after nursing set it up. R10 also had an order for Flovent HFA 110 micrograms (mcg) inhale orally two time a day for COPD 1-2 puffs, shake well: rinse mouth after use. The physician order for Flovent HFA inhaler did not indicate self administration.<br><br>R10's admission minimum data set (MDS) dated 5/19/14, indicated R10 was cognitively intact with no impairment of upper extremity range of motion. The current care plan dated 6/12/14, indicated R10 had recent impaired cognitive function which had cleared.<br><br>During an interview on 6/10/14, at 13:15 p.m. RN-C stated R10 was assessed to be able to self administer medications after setup. RN-C verified there was no specific order for R10 to self administer the inhaler, or to have it at bedside.<br><br>On 6/10/14, at 13:40 p.m. the director of nursing (DON)-A stated R10 was assessed to be able to self administer medications after set up, but there was no physician's order for self administration of the inhaler, or to have it at bedside. | F 176 | | |

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| F 176 | Continued From page 10<br><br>R10's care plan dated 6/9/14, indicated R10 could self administer oral medications after nursing set up, and nebulizers after nursing set up, but did not address self administration of inhalers.<br><br>R10's self administration of medication assessment dated 6/3/14, indicated he was safely able to administer all oral medications after nursing set up.<br><br>A signed physician's orders dated 6/4/14, indicated R10 was OK to self administer oral medication after nursing set-up, and was OK to self administer nebulizers after nursing set-up.<br><br>The medication administration record for R10 dated June 2014, did not direct nursing to allow R10 to self administer the Flovent HFA inhaler. | F 176 | | |
| F 282 SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to follow the care plan for 1 of 2 residents (R371) reviewed for pressure ulcers.<br><br>Findings include:<br><br>R371 had been admitted on 6/4/14, for | F 282 | F282 D (Also MN Statute 2565)<br>1. Corrective Action:<br>A. Patient 371 has been re-assessed related to pressure relief needs and a cushion has been provided for the wheel chair. The care plan has been updated.<br>2. Corrective Action as it applies to Other Patients: All patients have the | 7/21/14 |

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| F 282 | Continued From page 11<br>rehabilitation according to the Order Summary Report dated 6/4/14. The report identified diagnosis including right (R) trochanter (hip) pressure ulcer (PU,) sacral wound and left (L) hip wound.<br><br>The Admission Skin Assessment dated 6/4/14, indicated R371 was alert and oriented. The assessment identified a stage two PU on the R hip that measured 0.8 centimeters (cm) x 0.4 cm and a stage two PU on the sacrum that measured 1.2 cm x 0.4 cm. The assessment note indicated both wounds had been assessed and covered with dressing as ordered. The assessment further identified a stage four PU on the L hip that was treated with a wound vac. The assessment note indicated the L hip wound measured 2.8 cm x 1.9 cm x 2.9 cm with 4.6 cm tunneling at 9 o'clock and 3.2 cm tunneling at 6 o'clock. The assessment described yellow tissue at 12 o'clock and exposed bone at 5-6 o'clock with general undermining from 6-10 o'clock. The licensed nurse analysis summery note specified information to be care planned included preventive measures in place, including a pressure relief mattress and chair pad.<br><br>R371's care plan dated 6/4/14, identified stage four PU on L hip, and stage two PU of R hip and sacrum related to immobility and directed pressure relief on bed and chair.<br><br>During observations on 6/10/14, 6/11/14 and 6/12/14, R371 was observed seated in a recliner without a pressure relief chair pad. Observation of R371's room revealed no visible pressure relief chair pad.<br><br>On 6/11/14, at 11:22 a.m. during interview R371 | F 282 | potential to be affected by this deficient practice.<br>A. The policy and procedure for Pressure Ulcer Prevention was reviewed and revised to include the need for appropriate Pressure Relief in bed and wheelchair.<br>B. The Care Planning Policy has been reviewed and revised as appropriate.<br>C. All patients will be evaluated and re-assessed as necessary to assure they are provided with the appropriate pressure relief devices. Care plans will be updated as necessary.<br>D. The Pressure Ulcer Prevention Policy which includes the need to provide appropriate pressure relief to all surfaces and the Care Planning Policy will be reviewed with Nursing Staff at the Nursing Meeting which will be held on: July 7, 8, 9, 11, 12, 14, 15, 2014.<br><br>3. Date of Completion:<br>July 21, 2014.<br><br>4. Reoccurrence will be Prevented by:<br>A. DON or designee will conduct random audits daily for two weeks, then weekly for one month and then monthly for one quarter.<br><br>5. The Correction will be Monitored by:<br>A. DON or designee.<br>B. The QAPI Committee will review the audit results on a monthly basis and provide further direction, as needed. The QAPI committee will determine when the audits may be discontinued. | |

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| F 282 | Continued From page 12<br>was unable to recall if the facility had offered the use of a pressure relief cushion and stated, "I could probably use one."<br><br>On 6/11/14, at 1:30 p.m. registered nurse (RN)-A verified there had been no pressure relief chair pad utilized. RN-A stated R371's care plan included a pressure relief pad in chair and stated, "It should be there."<br><br>On 6/11/14, at 1:49 p.m. the director of nursing (DON) stated the expectation that were provided a pressure relieving pad for sitting, and stated, "It's standard and particularly because of the pressure ulcers." DON verified the care plan had not been followed.<br><br>Request made for policy regarding care plan interventions not provided. | F 282 | | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and document review, the facility failed to provide pressure relief for 2 of 3 residents (R371, R81) reviewed for | F 314 | F314 D (also MN Statute 2900)<br>1. Corrective Action:<br>A. Patient 371 has been re-assessed | 7/21/14 |

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| F 314 | Continued From page 13<br>pressure ulcers.<br><br>Findings include:<br><br>R371's Order Summary Report dated 6/4/14, indicated R371 was admitted on 6/4/14, with diagnosis to include right (R) trochanter (hip) pressure ulcer (PU,) sacral wound and left (L) hip wound.<br><br>Review of R371's Admission Skin Assessment dated 6/4/14, identified a stage two PU on the R hip had measured 0.8 centimeters (cm) x 0.4 cm and a stage two PU on the sacrum had measured 1.2 cm x 0.4 cm. The assessment note indicated both wounds had been assessed and covered with dressing as ordered. The assessment further identified a stage four PU on the L hip had been treated with a wound vac. The assessment note indicated the L hip wound measured 2.8 cm x 1.9 cm x 2.9 cm with 4.6 cm tunneling at 9 o'clock, and 3.2 cm tunneling at 6 o'clock. The assessment described yellow tissue at 12 o'clock and exposed bone at 5-6 o'clock with general undermining from 6-10 o'clock. The assessment specified the preventive measures in place included pressure relief mattress and chair pad, weekly skin assessment and Braden score, daily monitoring of areas of skin assessment, wound vac dressing to be changed Monday-Wednesday-Friday and Mepilex dressings to R hip and sacrum to be changed every three days, turn and reposition every 2 hours, elevating of heels and off-loading.<br><br>R371's care plan dated 6/4/14, identified stage four PU on L hip, and stage two PU of R hip and sacrum related to immobility. The care plan included pressure relief on bed and chair. | F 314 | related to pressure relief needs and a cushion has been provided for the wheel chair. The care plan has been updated.<br>B. Patient 81 discharged.<br><br>2. Corrective Action as it applies to Other Residents: All patients have the potential to be affected by this deficient practice.<br><br>A. The policy and procedure for Pressure Ulcer Prevention was reviewed and revised to include the need for appropriate Pressure Relief in bed and wheelchair.<br>B. The Care Planning Policy has been reviewed and revised as appropriate.<br>C. All patients will be evaluated and re-assessed as necessary to assure they are provided with the appropriate pressure relief devices. Care plans will be updated as necessary.<br>D. The Pressure Ulcer Prevention Policy which includes the need to provide appropriate pressure relief to all surfaces and the Care Planning Policy will be reviewed with Nursing Staff at the Nursing Meeting which will be held on:<br>July 7, 8,9, 11, 12, 14, 15, 2014.<br><br>3. Date of Completion: July 21, 2014.<br><br>4. Reoccurrence will be Prevented by:<br>A. DON or designee will conduct random audits daily for two weeks, then weekly for one month and then monthly for one quarter.<br><br>5. The Correction will be Monitored by: | |

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| F 314 | Continued From page 14<br><br>During observations on 6/10/14, 6/11/14 and 6/12/14, R371 was observed seated in a recliner without a pressure relief chair pad. Observation of room revealed no pressure relief chair pad present in room.<br><br>On 6/11/14, at 1:30 p.m. registered nurse (RN)-A verified the lack of a pressure relief chair pad availabe in R371's room. RN-A reported residents care plan included a pressure relief pad in chair and stated, "It should be there."<br><br>On 6/11/14, at 1:49 p.m. the director of nursing (DON) stated the expectation of residents being provided pressure relief for sitting, and stated, "It's standard and particularly because of the pressure ulcers." DON verified the care plan had not been followed.<br><br>A computer-generated Diagnosis Report dated 6/12/14, indicated R81's diagnoses included diabetes type 2, osteoporosis, hepatic encephalopathy and traumatic bone fracture.<br><br>R81's admission Minimum Data Set (MDS) dated 5/15/14, indicated R81 was cognitively intact, was at risk for the development of pressure ulcers, had no current pressure ulcers, had a pressure reduction device on the chair and the bed, and was on a turning and repositioning program. A Care Area Assessment (CAA) dated 5/18/14, indicated R81 had a reddened, blanchable area on left buttock noted on admission. The CAA further indicated R81 was at risk for pressure-related skin problems due to a report of R81 having this reddened, blanchable, non-pressure related area for a year. The CAA also indicated R81 required assistance with | F 314 | C. DON or designee.<br>D. The QAPI Committee will review the audit results on a monthly basis and provide further direction, as needed. The QAPI committee will determine when the | |

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| F 314 | Continued From page 15<br>turning and repositioning, was receiving treatment to the reddened buttock area, and had a pressure-reducing mattress and a wheelchair seat in place. The CAA provided a goal to keep the left buttock area from a more advanced stage of skin breakdown.<br><br>A Skin Assessment dated 5/10/14, indicated R81 had a potential pressure area on the left buttock. The Assessment described the left buttock area as purple and blanchable and measured 11 cm by 7 cm.<br><br>A Skin Assessment dated 5/26/14, described R81's left buttock area as fading purple, blanchable, intact skin, measuring 9 cm by 6 cm. The Assessment further described a suspected deep injury on R81's right heel measuring 2.0 cm by 1.9 cm with irregular wound edges. The Assessment noted R81's right heel to be brown in color, non-blanchable, and mushy texture. The Assessment indicated R81's physician had been contacted for a change in orders for treatment. The Assessment further indicated the preventive measures to include posey boot to heel while in bed and wheelchair, turn and reposition in wheelchair every 1 hour and off load for 1 minute, skin prep to right heel bid [twice daily], and pressure relieving mattress and wheelchair cushion.<br><br>A SBAR Communication Form and Progress Note physician signed and dated 5/30/14, directed skin prep to right heel bid [twice daily] until healed, Posey boot to right heel in bed and wheelchair, and OK for air mattress overlay.<br><br>R81's Plan of Care (POC) revised 5/26/14, indicated a potential for skin breakdown related to | F 314 | | |

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| F 314 | Continued From page 16 | F 314 | | |

weakness and use of walker. The POC further indicated R81 had a reddened, blanchable area to the left buttock as well as a DTI (deep tissue injury) to the right heel. R81's POC included the following interventions: encourage good nutrition and hydration in order to promote healthier skin, keep skin clean and dry, use caution during transfers and bed mobility, turn and reposition every 2 hours and as needed, posey boot to protect right heel, alternating air mattress, and skin prep to right heel.

On 6/11/14, at 8:36 a.m. R81 was observed seated in the wheelchair in the room. Nursing assistant (NA)-A entered R81's and assisted R81 to stand. R81's wheelchair cushion was observed and was noted to be foam, covered with a non-removable, gray, plastic material. R81's gray wheelchair cushion was observed to be covered with a white, quilted, fabric cover, referred to as a "soaker pad" by NA-A. R81's bed was observed and was noted to have a regular, foam mattress.

On 6/12/14, at 11:25 a.m. registered nurse (RN)-A stated most residents receive the standard dark blue or black, nylon covered foam wheelchair cushion for pressure-reduction. R81's wheelchair cushion was observed with RN-A. RN-A confirmed R81's gray, plastic-covered, foam wheelchair cushion was not the facility's standard issue pressure-reducing chair cushion, should not be covered with a "soaker pad", and the plastic covering was not breathable as to prevent healing of R81's buttock area skin issues. RN-A verified R81's bed lacked an air mattress overlay. Upon returning to the nurses' station and observing the 5/30/14, physician orders in R81's medical record, RN-A verified the orders had

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| F 314 | Continued From page 17<br>never been transcribed off the chart for the air mattress overlay.<br><br>An Ecumen Lean Wound System, Standing Orders Guideline dated 2013, was provided as the facility's policy on pressure ulcer care. The Guideline directed to use pressure reduction devices/surfaces in bed, chair, and wheelchair for wound care prevention basics. | F 314 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.<br><br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. | F 329 | | 7/21/14 |

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| F 329 | Continued From page 18<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure monitoring for side effects of an antidepressant medication were completed for 1 of 5 residents (R81) whose medications were reviewed.<br><br>Findings include:<br><br>An Admission Minimum Data Set (MDS) dated 5/15/14, indicated R81's diagnoses included depression. The MDS further indicated R81 was cognitively intact, had no mood or behavior problems, and had taken an antidepressant medication for the past 7 days reviewed. A Care Area Assessment (CAA) dated 5/18/14, indicated R81 was using Zoloft [an anti-depressant] 100 mg by mouth daily for the management of depression. The CAA further indicated the Zoloft was not a new medication for R81 and at this time the depression appeared to be stable, however, R81 had multiple health issues and the depression could resurface. The CAA also indicated R81 was not experiencing any side effects at this time related to the Zoloft, and R81's behaviors and mood were being monitored at this time.<br><br>A computer-generated Order Summary Report dated 5/8/14, directed Zoloft [an anti-depressant medication] 100 mg by mouth in the morning for depression; chart "p2" side effects. The Order Summary Report further directed for the anti-depressant medication to monitor for anxiety, restlessness, dizziness, tremors, sweating, sleepiness, dry mouth, diarrhea, nausea, constipation, headaches, insomnia. The Order Summary Report further directed to document "Y" | F 329 | F329 D (Also MN Statute 21540)<br>1. Corrective Action:<br>Patient 81 discharged.<br><br>2. Corrective Action as it Applies to other Patients: All patients have the potential to be affected by this deficient practice.<br>A. The Psychotropic Medication Policy was reviewed and revised to reflect the need for Side Effects Monitoring.<br>B. The HUCs and Licensed Nurses have been trained on order entry in PCC. Assuring that the side effects are on the MAR with spaces to mark whether there is a side effect noted was part of the training. The training occurred on : June 24,2014 and July 7, 8, 9, 11, 12, 14, and 15 2014.<br>C. All patients receiving psychotropics have been evaluated and side effects monitoring is now in place on both the MAR and the care plan.<br>D. The nursing staff will be educated on the Psychotropic Medication policy at the Nursing Meeting on: July 7, 8, 9, 11, 12, 14, and 15 2014.<br><br>3. Date of Completion:<br>July 21, 2014.<br><br>4. Reoccurrence will be Prevented by:<br>DON or designee will conduct random audits daily for two weeks, then weekly for one month and then monthly for one quarter.<br><br>5. The Correction will be Monitored by: | |

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| F 329 | Continued From page 19<br>if monitored and non of the above observed, "N" if monitored and any of the above observed, select chart code "Other/See Nurses Notes" and progress note findings.<br><br>R81's Plan of Care (POC) dated 5/8/14, indicated an anti-depressant medication, Zoloft, was used for depression and directed to monitor and document side effects and effectiveness of the Zoloft every shift.<br><br>Review of R81's electronic Medication Administration Record (e-MAR) dated 5/2014, and 6/2014, indicated R81 had received Zoloft 100 mg by mouth daily. Review of R81's electronic Treatment Administration Record (e-TAR) indicated a lack of monitoring of the side effects and/or effectiveness.<br><br>R81 was frequently observed during the survey week of 6/9/14, through 6/12/14, and was noted to be without signs or symptoms of depression not were any side effects of the antidepressant observed.<br><br>On 6/12/14, at 8:24 a.m. the director nursing (DON) stated residents' medication side effects and effectivness are charted on the e-TAR as directed by the POC.<br><br>On 6/16/14, at 10:00 a.m. during a telephone interview, the DON stated the only documentation for the monitoring of R81's antidepressant side effects was the Physician's Order Summary Report. The DON further stated the Order never made it to R81's e-TAR in the computer system to be monitored by nursing staff. | F 329 | A. DON or designee.<br>B. The QAPI Committee will review the audit results on a monthly basis and provide further direction, as needed. The QAPI committee will determine when the audits may be discontinued. | |

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| F 332 | Continued From page 20 | F 332 | | |
| F 332 SS=D | 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE<br><br>The facility must ensure that it is free of medication error rates of five percent or greater.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to ensure a medication error rate of less than 5% for 2 of 5 residents (R10, R364) whose medications were observed to be administered.<br><br>Findings include:<br><br>The facility had 5 medication errors in 28 opportunities resulting in an error rate of 18%.<br><br>R364 did not have her eye drops administered appropriately resulting in 3 medication errors. According to the Order Summary Report R364 was admitted on 5/29/14 with multiple diagnoses including glaucoma. R364 had physician orders for 3 different eye medications: Acular Solution 0.5% (non-steroidal antiinflammatory) Instill 1 drop in left eye 4 times a day for glaucoma, Natures Tears Solution 0.4% Instill 1 drop in left eye 4 times a day for eye care, Prednisolone Acetate Suspension 1% (steroidal antiinflammatory) Instill 1 drop in left eye 4 times a day for glaucoma. R364 also had a physician's order for Allopurinol tablet 100 mg give one tablet in the morning for gout - Administer with a full glass of water.<br>On 6/10/14 at 7:30 a.m. R364 was observed to receive her eye drops from RN-E. RN-E | F 332 | F332 D (Also MN Statute 21545)<br>1. Corrective Action:<br>Patients 10 and 364 are now having their medications administered correctly in accordance with facility policy.<br>2. Corrective Action as it Applies to other Patients: All patients have the potential to be affected by this deficient practice.<br>A. The Medication Administration policies have been reviewed and revised.<br>B. All patients have been re-evaluated related to their medication administration needs. Changes were made to their MARs and Care Plans as appropriate.<br>C. The licensed staff were educated related the Medication Administration policies on:<br>July 7, 8, 9, 11, 12, 14, and 15 2014.<br>3. Date of Completion:<br>July 21, 2014.<br><br>4. Reoccurrence will be Prevented by:<br>DON or designee will conduct random audits daily for two weeks, then weekly for one month and then monthly for one quarter.<br><br>5. The Correction will be Monitored by: | 7/21/14 |

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| F 332 | Continued From page 21<br>administered 1 drop of Prednisolone in the left eye, immediately followed by 1 drop of Acular in the left eye, which was immediately followed by the Natures Tears solution 1 drop to the left eye. Standard of practice and the undated facility policy for Eye Drop Administration directed staff to wait 5 minutes between drops of different eye medications. R364 was then provided her oral medications with the water glass already in her room. R364 was observed to swallow medications with sips of water. RN-E did not encourage R364 to drink more water so only sips were consumed. The undated facility policy for Medication Administration Procedures directed staff to "Follow all medications with 4-8 ounces of water." This resulted in a total of 4 medication errors for R364.<br>R10 did not have his medication administered with the appropriate amounts of fluid. According to the Order Summary Report dated 6/2014 R10 had multiple diagnoses including pneumonia and Chronic airway obstruction. R10 had a physician's order which read: Mucinex Tablet Extended Release 12 Hour 600 mg Give 1 tablet two times a day for congestion Do not crush, Take with full glass of water (use full blue cup off of cart - measures 4 ounces).<br><br>On 6/10/14 at 7:00 a.m. R10 was observed to receive his oral medications from RN-E. R10 took sips of water from the glass in his room. Although RN-E provided him with fresh water in the glass, she provided no encouragement to drink 4 ounces of water with the medications. This resulted in one med error for R10.<br><br>On 6/10/14 at 1:00 p.m. RN-E stated there was no specific order for a wait time between the administration of the eye drops. RN-E further | F 332 | C. DON or designee.<br>D. The QAPI Committee will review the audit results on a monthly basis and provide further direction, as needed. The QAPI committee will determine when the audits | |

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| F 332 | Continued From page 22<br>stated that R364 informed her how to give the eye drops and that's how she administered them.<br><br>RN-C stated on 6/10/14 at 1:15 p.m. that the "Standard of nursing practice is to wait 5-10 minutes between eye drops." RN-C also verified the facility policy for medication administration was to provide the oral medications with a full glass of water and to encourage the resident to drink it. On 6/10/14 at 1:40 p.m. the director of nursing indicated staff should wait 5-10 minutes between the eye drops. After reviewing the facility policy the director of nursing clarified staff should wait 1-2 minutes between drops of the same medication and 5 minutes between drops of different medications. | F 332 | | |
| F 441 SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to | F 441 | | 7/21/14 |

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| F 441 | Continued From page 23<br>prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and document review, the facility failed to provide appropriate infection control procedures during medication administration for (R364, R10, R370); failed to document adequate justification for antibiotic use for 3 of 3 residents (R375, 376, R95) for whom logs were reviewed; and did not utilize a method for tracking and trending employee and resident infections. This had the potential to affect 50 of 50 residents in the facility.<br><br>Findings included:<br><br>R364's admission Order Summary Report dated 5/29/14 indicated diagnoses including dementia, diabetes, and end stage renal disease. Physician orders included Flonase Suspension 50 mcg/act (micrograms/actuation) 2 puff in both nostrils in the morning, and Prednisolone Acetate | F 441 | F441 F (Also MN Statute 21390)<br>1. Corrective Action:<br>Patient 370 discharged.<br>A. Patients 364 and 10 are now receiving their medications with the nurses observing the correct Infection Control Practices.<br>B. Patient 364 received a new bottle of eye drops.<br>C. Patients 375, 376 and 95 are no longer receiving Antibiotic Therapy for treatment of UTI□s.<br>2. Corrective Action as it applies to other Patients: All Patients have the potential to be affected by this deficient practice.<br>A. The McGeer□s Infection Criteria has been reviewed. The physician will be contacted for further instructions when Patient□s with orders do not meet the | |

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| F 441 | Continued From page 24<br>Suspension 1% instill one drop in left eye for times a day.<br>On 6/10/14 at 7:20 a.m. R364 was provided the Flonase suspension nasal spray to self administer. R364 appropriately administered the Flonase herself. Registered nurse (RN)-E took the Flonase nasal spray from R364 and gave her Prednisolone eye drops to self administer. R364 took the eye drops and put the medication up her left nostril and attempted to plug her right nostril to spray the eye medication as a nasal spray. RN-E then told R364 the eye drops didn't go there and that she would help R364. Without cleansing the eye drop bottle, RN-E administered the Prednisolone eye drops, one drop to R364's left eye.<br><br>On 6/10/14 at 1:00 p.m. RN-E stated she did not see R364 actually put the eye drops up her nose. RN-E stated if she was aware she had done that, she would have removed the drops and ordered a new bottle. On 6/10/14 at 1:40 p.m. the director of nursing verified the eye drops should not have been given. She stated she would have expected staff to rinse the nostril with normal saline and replaced the bottle of eye drops.<br><br>On 6/10/14 at 7:00 a.m. RN-E. was observed to set up 5 oral medications for R10 by popping the individual doses out of the card into her bare hand before being placed in the medication cup. On 6/10/14 at 7:15 a.m. R370 had 7 oral medications set up and administered by RN-E, again with the doses popped into RN-E's bare hand. On 6/10/14 at 7:30 a.m. R364 had 5 medications set up in the same manner before administration by RN-E.<br><br>On 6/10/14 at 12:40 p.m. RN-E stated that when | F 441 | McGeer□s criteria for infection.<br>B. The Infection Control Policy for UTI□s has been reviewed and revised.<br>C. The Medication Administration Policies, including Infection Control practices were reviewed and revised.<br>D. The DON (designated Infection Control Practitioner) has reviewed and revised the Infection Control tracking tool to include on-going tracking of both patient and staff infections at the time of illness.<br>E. Nursing staff members were educated on the Infection Control Tracking Tool, McGeer□s Infection Criteria, Medication Administration and Infection Control Policies at the Nursing Meeting held on: July 7, 8, 9, 11, 12, 14, and 15, 2014.<br>3. Date of Completion: July 21, 2014.<br><br>4. Reoccurrence will be Prevented by: DON or designee will conduct random audits daily for two weeks, then weekly for one month and then monthly for one quarter.<br><br>5. The Correction will be Monitored by:<br>E. DON or designee.<br>F. The QAPI Committee will review the audit results on a monthly basis and provide further direction, as needed. The QAPI committee will determine when the audits may be discontinued. | |

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she tried to pop the pills directly into the medication cups, "They wind up all over the place!" so she has developed the practice of placing them into her bare hand first and then placing them by hand into the medication cup. On 6/10/14 at 1:15 p.m. RN-C stated that nurses should be popping the pills from the medication cards or bottles directly into the medication cups. At 1:30 p.m. RN-C stated, "To clarify - we don't' really ever touch meds with bare hands." RN-C further clarified that if staff needed to touch meds directly, hand washing and gloving should occur. On 6/10/14 at 1:40 p.m. the director of nursing stated that bare hands should not touch oral medications.

The undated facility policy for oral medication administration, provided by the facility as current, directed staff to pour medications into the medication cup. An undated facility policy for general medication administration guidelines indicated if the "integrity or sanitation of the medication is in questions (e.g. medication dropped on floor, inadvertently touched by a staff member, spit out, etc.) an explanatory note" is entered and another medication is utilized.

During review of infection control (IC) logs from 11/1/13, to 5/31/14, with the director of nursing (DON) on 6/12/14, at 10:10 a.m. the following was noted:

R375's physician ordered Cipro (antibiotic) 250 milligrams (mg) twice a day (bid) for seven days on 11/4/13. Review of the IC logs indicated a urine specimen positive for bacteria; however, there were no further symptoms identified. The DON reported the Cipro had been ordered to treat a UTI.

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| | 245215 | A. BUILDING _____ B. WING _____ | 06/12/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAKESHORE INC | 4002 LONDON ROAD DULUTH, MN 55804 |

| (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 441 | Continued From page 26<br><br>R376's physician's order dated 11/17/13, directed Cipro 500 mg bid for five days for UTI. Review of the IC logs identified symptoms of a positive urine test and incontinence. There were no additional documented symptoms of UTI requiring antibiotic therapy.<br><br>R95's physician ordered Cipro 500 mg bid for three days on 1/29/14. The IC logs did not include identified symptoms of UTI. The DON reported the Cipro had been ordered to treat a UTI.<br><br>During interview on 6/12/14, at 10:10 a.m. the DON verified the lack of justification for antibiotic use.<br><br>The facility's infection control (IC) logs from 7/1/13, to 5/31/14, lacked evidence to indicate data was analyzed or trends identified to determine corrective action to prevent the spread of the infections at the time the infection occurred. There was no indication of tracking resident and staff illness as they occurred.<br><br>During interview on 6/11/14, at 2:01 p.m. director of nursing (DON), who was identified as the infection control nurse, verified that she did not track and/or trend infections (both residents and employees) while infections were ongoing. Resident IC logs were filled in at the end of each week, and staff IC logs were filled in at the end of each month. The DON further stated it would have been difficult to prevent an outbreak, and /or reoccurrence of an infection if not reviewed as the infection occurred.<br><br>The facilities Infection Control and Prevention Program policy revised 5/2011, directed staff | F 441 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245215 | A. BUILDING _____ B. WING _____ | 06/12/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LAKESHORE INC | 4002 LONDON ROAD DULUTH, MN 55804 |

| (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 441 | Continued From page 27<br>designated to serve as coordinator of the IC program to monitor daily reports to help identify potential infections and outbreaks. Request made for UTI treatment policy none provided. | F 441 | | |
| F 465 SS=C | 483.70(h)<br>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON<br><br>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and document review, the facility failed to provide a clean kitchen environment. This had the potential to affect 50 of 50 residents in the facility.<br><br>Findings include:<br><br>During an initial kitchen tour on 6/9/14, at 12:20 p.m. with the food service director-D, the reach-in cooler near the serving area was observed to have dried splashes of liquids and food particles on the outside door and door handles, and inside walls. The food service director-D, verified the cooler was dirty and stated they were to be cleaned weekly.<br><br>On 6/9/14, at 4:30 p.m. the floor under and behind the big steam jacket kettle was observed to have a build up of dirt. The shelf holding plates above the food service area, was observed to have a dusty, greasy build up between the stacks of plates. The food service director-D verified the | F 465 | F465<br><br>1. Corrective Action:<br>Equipment and General Cleaning Policy has been reviewed and revised to include the following tasks.<br><br>A. Wiping down the two shelves above the steam table making sure to remove plates to eliminate any dust, debris, and or food particles.<br>B. Cleaning of behind the steam jacket and back oven with broom followed by deck scrubbing the floor and wiping down the back wall.<br>C. The cleaning of the reach-in cooler and freezer including wiping down the outside and inside of doors, along with interior walls and floor, changing over of the sheet pans and checking dates of prepped items. | 7/21/14 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245215 | A. BUILDING _____ B. WING _____ | 06/12/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKESHORE INC** | **4002 LONDON ROAD DULUTH, MN 55804** |

| (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 |
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| F 465 | Continued From page 28<br>shelf was not on the cleaning schedule.<br><br>On 6/11/14, at 10:00 a.m. the food service director-D stated the reach-in cooler next to the food service area had been cleaned on 6/9/14, following the initial kitchen tour. The cooler was observed to have some of the same dried splashes of liquids and food particles on the inside walls with more concentration at the level of the trays/shelves. The food service director verified the areas of food particles, and also verified the shelves with the plates above the food service area did have greasy build up between the plates that had been removed when cleaned. The holding ovens were observed to have food particles and crumbs along the sides of the bottom of the oven. The food service director verified there were food particles and crumbs in the holding ovens.<br><br>The undated facility policy and procedure for equipment and general cleaning that was provided on 6/11/14, by the food service director-D, indicated all equipment will be properly cleaned and sanitized by staff following each use and inspected for proper cleanliness prior to each use. It further indicated cleaning is understood to mean the removal of all visible debris. The policy and procedure addressed direction for cleaning of the refrigerators and freezers on the PODS (units) and the walk-in cooler and freezer, but lacked direction for cleaning of the reach-in coolers and freezers, holding ovens, shelves, and floors in the kitchen. | F 465 | 2. Date of Completion: July 21, 2014<br><br>3. Reoccurrence will be Prevented by:<br>A. Staff education provided will be provided on July 10, 2014.<br>B. Random audits will be conducted two times weekly for two weeks, then weekly for one month and monthly for one quarter. Findings will be reported to the QAPI team for review and discussion.<br><br>4. The Correction will be Monitored by:<br>A. The Dietary Manager, Executive Chef or the Dietitan.<br>B. The QAPI Committee will review the audit results on a monthly basis and provide further direction, as needed. The QAPI Team will determine when the audits may be discontinued. | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245215 | A. BUILDING _____ B. WING _____ | 06/12/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKESHORE INC** | **4002 LONDON ROAD DULUTH, MN 55804** |

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|---|---|---|---|---|
| F 465 | Continued From page 29 | F 465 | | |

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

F5215023

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245215 | A. BUILDING **02 - NEW REPLACEMENT BLDG** B. WING _____ | **06/10/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKESHORE INC** | **4002 LONDON ROAD DULUTH, MN 55804** |

| (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<br><br>FIRE SAFETY<br><br>A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Lakeshore Lutheran Home was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 NewHealth Care.<br><br>Lakeshore Lutheran Home is a two story building with a full basement, constructed in 2004 and opened in 2005. The construction type is determined to be Type I(443).<br><br>The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility has a licensed capacity of 60 beds, the census was 50 at the time of inspection. | K 000 | | |

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

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.

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY COMPLETE: |
|---|---|---|---|
| | 245215 | A. BUILDING: _____ B. WING _____ | 7/17/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKESHORE INC** | **4002 LONDON ROAD DULUTH, MN** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| **F 156** | 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES |

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

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

The above isolated deficiencies pose no actual harm to the residents

| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | PROVIDER # | MULTIPLE CONSTRUCTION | DATE SURVEY COMPLETE: |
|---|---|---|---|
| | **245215** | A. BUILDING: _____ B. WING _____ | **7/17/2014** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **LAKESHORE INC** | **4002 LONDON ROAD DULUTH, MN** |

| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| **F 156** | Continued From Page 1 |

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to notify a resident whose skilled rehabilitation services were being discontinued at least two days prior to the termination of services. This finding affected one (R286) of four residents reviewed for liability notice and appeal rights in the Stage 2 sample of 36.

Findings include:

During an interview on 7/17/14 at 10:45am, the Business Office Manager (BOM) stated that R286's last day of Medicare coverage was 3/25/14. The BOM reported that R286 had opted to remain at the facility from 3/26/14 - 4/3/14.

Review of the "Notice of Medicare Non-Coverage" that had been provided to R286, revealed that the notice informing R286 that skilled services would be discontinued on 3/25/14, was signed by R286 on 4/2/14.

During the above interview, the BOM indicated that she had not been informed of R286's decision to remain at the facility from 3/26/14 - 4/3/14 until 4/1/14.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of Minnesotans*

Electronically submitted
June 23, 2014

Mr. John Korzendorfer, Administrator
Lakeshore Inc
4002 London Road
Duluth, Minnesota 55804

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5215025

Dear Mr. Korzendorfer:

The above facility was surveyed on June 9, 2014 through June 12, 2014 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, Compliance Monitoring 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 Patricia Halverson at (218) 302-6151or email: Patricia.Halverson@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
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697