Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 7, 2025

Administrator
Lakeside Generations Health Care Center
439 William Avenue East
Dassel, MN 55325

RE: CCN: 245533
Cycle Start Date: December 6, 2024

Dear Administrator:

On January 31, 2025, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

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February 7, 2025

Administrator
Lakeside Generations Health Care Center
439 William Avenue East
Dassel, MN 55325

Re: Reinspection Results
Event ID: PGLF12

Dear Administrator:

On January 31, 2025, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 6, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 26, 2024

Administrator
Lakeside Generations Health Care Center
439 William Avenue East
Dassel, MN 55325

RE: CCN: 245533
Cycle Start Date: December 6, 2024

Dear Administrator:

On December 6, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 6, 2025 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by June 6, 2025 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 **and Minnesota Statute 144A.10 subd 15**, 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245533	A. BUILDING _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE GENERATIONS HEALTH CARE CENTER	439 WILLIAM AVENUE EAST DASSEL, MN 55325

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 12/2/24 through 12/6/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 12/2/24 through 12/6/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55333939C (MN103538) H55331721C (MN102340) The following complaint was reviewed: H55331705C (MN108552) with a deficiency cited at F684. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/04/2025

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

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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to review potential	F 657	Plan of Correction for Deficiency F657 It is the policy of Cassia Lakeside	1/27/25

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F 657	Continued From page 2 options and interventions for 1 of 2 residents (R10) reviewed for pressure ulcer/injury. Findings include: R10's quarterly Minimum Data Set (MDS) dated 10/21/24, indicated R10 was alert and oriented. R10 was identified as having no functional limitation in range of motion (ROM) in her upper or lower extremeties, and ambulated independently with the use of a walker. R10 was identified as being independent with personal hygiene, able to complete upper and lower body dressing, with the exception of putting on and taking off shoes. The MDS indicated R10 was independent with ambulation, transfers, and bed mobility. The MDS indicated R10 was able to walk 150 feet and did not require the use of a wheelchair. R10's medical diagnoses included medically complex conditions, anemia, hypertension (high blood pressure), peripheral vascular disease/peripheral arterial disease(PVD/PAD-a disease that caused problems with the blood vessels or arteries outside your heart or brain), diabetes (a group of diseases that affect how the body uses blood sugar (glucose), osteoarthritis, and age related osteoporosis. R10's admission care plan dated 6/26/18, identified R10 had impaired mobility related to age, weakness. Additionally, R10 had a trochanter fracture of the left hip (fractures of the proximal femur (thigh bone) at the area where the bone attaches to the hip, most commonly seen following ground-level falls in the elderly. The care plan identified R10 was at risk for falls related to history of syncope (fainting episodes) and other contributing factors. R10's admission	F 657	Generations to comply with the regulation cited under F657, which requires the facility to review potential options and interventions for residents with pressure ulcers/injuries. To assure continued compliance, the following plan has been put into place: _____ Corrective Actions for Affected Resident " Resident R10: R10 did not develop a pressure ulcer, she was at risk only. Appropriate interventions are in place based on the individualized assessment and R10 preference. Resident tissue tolerance testing completed. Revised plan of care interventions based on nursing assessment. Risks vs benefits completed. _____ Actions to Identify Other Potential Residents: " All residents with a history of skin breakdown or limited mobility who are hospitalized and experience a change in condition have the potential to be affected by this deficient practice upon return to the facility. _____ Measures to Prevent Recurrence: " Re-education will be provided by the DON and/or designee to all licensed nursing staff beginning December 23rd 2024 on Change in condition and readmission assessments, policy and procedures. Monitoring and Auditing DON and/ or designee will perform	

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F 657	Continued From page 3 diagnoses included a periprosthetic fracture (fracture that occurs around an orthopedic implant) around internal prosthetic right hip joint. R10's care plan was reviewed upon return from the hospital on 11/21/24, related to ADL's. The problem statement was initiated on 6/26/18 and indicated R10 was status post trochanter fracture of left hip, however, lacked updated diagnosis of right femur fracture. The care plan interventions were updated to reflect the use of EZ stand with weight bearing as tolerated on 11/20/24. The interventions identified resident received assist of 2 with bed mobility, however, that was initiated on 6/26/18, with no current updates. On 12/2/24, identified R10 was at risk for further skin alterations related to Braden score and multiple other factors, however, the problem statement lacked indication of recent right humerus fracture, or the fact that resident no longer rests in her bed to decrease pressure points. The interventions remain unchanged with the exception of addition of "Treatment as ordered." The interventions included the use of pressure redistribution mattress, implemented 11/16/20, however, no interventions were in place to identify R10 was not resting in bed, and lacked indication of interventions to accommodate return to bed for sleep/rest/off loading. On 12/2/24, at 6:51 p.m. R10 was seated in her recliner in her room. R10 had bruising surrounding her right, and significant bruising to her left arm. R10 stated she had fallen and fractured her right hip, below her replacement, when walking to the bathroom with her walker. R10 stated she had not tripped on anything, although, stated she had been light headed intermittently, but not severely. R10 stated she	F 657	assessment and care plan audits starting week of 1/6/2025 when a resident readmits with a change in condition from the hospital. The care plan is constantly changing and will be updated routinely in the electronic record to reflect the residents' current condition. Results of these audits will be reviewed by the facility QAPI committee, which will determine if further monitoring or audits are necessary. _____ _____ Responsible Person " Those responsible to maintain compliance will be: The Director of Nursing, or designee, is responsible for maintain compliance. _____ _____ Completion Date " The completion date for this plan of correction is January 27th, 2025.	

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F 657	Continued From page 4 had a "spot" on her buttocks, on which staff put a "patch" and salve. R10 stated the staff were unsure what was causing this "spot" but stated it was felt to be related to sitting in a chair. R10 stated she had added pillows to the seat of recliner and this was helpful. R10 stated she had used special cushions in the past but was not satisfied with this, and no longer used them. R10 stated she had slept in her recliner since her return from the hospital on 11/20/24, and had not slept in her bed since her return as it "was too painful". On 12/4/24, at 11:08 a.m., nursing assistant (NA)-C was observed with the transfer process from the recliner with the use of the EZ stand. Once upright in the EZ stand, R10 was assisted via the EZ stand into the bathroom. R10 refused observation of skin condition while in the bathroom. On 12/4/24, at 1:55 p.m. registered nurse (RN)-C stated R10 used a standard pillow in her recliner for pressure reduction. RN-C stated R10 had a foam cushion in her wheelchair for comfort. RN-C stated she would discuss the use of cushions with nursing and therapy to determine what was best to use as resident was chairbound/wheelchair bound. A review of narrative notes was completed and identified the following: On 11/20/24, at 4:59 p.m. , the Hospital Return Nurse Assessment was completed and identified the risk areas for skin in the following areas: decline in her ability to completed her activities of daily living (ADLs), decline in ADLs, fracture of right hip periprosthetic fracture, fragile skin, pain,	F 657		

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F 657	Continued From page 5 PVD, and sepsis. The assessment also identified R10 was bedfast/wheelchair bound, with a functional limitation in range of motion. A Braden Scale (an assessment used for prediction of pressure injury risk), was included within the assessment, and R10 was scored at 15-18, which identified R10 was "at risk" for skin breakdown. The document identified risk factors of mobility risk factors, and identified R10 was at risk for pressure injury. The assessment identified R10's ability to sleep over the past 5 days was rarely, or not at all impacted by injury. On 11/18/24, at 10:28 a.m., R10 had been found on the floor in front of her roommate's bed. R10 stated she was going to the bathroom, became dizzy, and fell. R10 was sent to the emergency department for assessment. A subsequent note of 11/18/24, at 1:58 p.m., indicated the facility received a call from family who stated R10 had broken her right femur (thigh bone) and was unsure as to when she would return to the facility. On 11/20/24, R10 returned to the facility. Upon return, R10 required increased assitance with care and transferred with the use of an EZ stand lift (a mechanical lift which uses a sling behind back), to provide support for transfers. A review was completed to determine if R10's being either wheelchair bound or in her recliner was identified. The notes were also reviewed for identification R10 did not lay down in bed to decrease pressure related to pain. A review was completed for education regarding potential risks and benefits of not using pressure relieving interventions, such as laying down in bed, use of pressure reduction cushions, etc. The following was noted:	F 657		

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F 657	Continued From page 6 On 11/23/24, at 10:02 p.m., the note indicated R10 was in recliner for the entire shift, however, lacked interventions in place for offloading, or change in position. The documentation lacked indication as to discussion of potential risks related to limited movement and impact on health. On 11/24/24 at 5:12 p.m., the note indicated R10 had been in her recliner most of the afternoon. The documentation lacked discussion of the risks and benefits. Pain interventions were offered. On 11/26/24 at 10:33 a.m., indicated R10 required increased with cares related to increase in pain, and impaired mobility. On 11/27/24 at 10:50 a.m., narrative note identified R10 required increased assistance with ADLs, including dressing, toileting, and bed mobility. On 11/30/24, at 10:07 p.m., the narrative note identified increased pain with transfers, but R10 denied pain when seated in chair (recliner). On 12/4/24 at 3:44 p.m., an interview was held with the director of nursing (DON) to discuss skin status on R10, and the potential for further skin breakdown related to lack of interventions. DON stated they had tried alternate cushions and R10 had refused. DON stated staff had explained risks and benefits. A request was made for documentation to review the interventions in place, assess provision of risks versus benefits with current interventions, and review with therapy for potential interventions. Additionally, the DON was informed although R10 had a pressure redistribution mattress in her bed, R10 did not	F 657		

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F 657	Continued From page 7 rest in bed due to the pain caused with laying down. Narrative notes up to the date of 12/5/24 at 11:47 a.m., written by the director of nursing, reviewed R10's current skin condition, and the potential risks and benefits of not using a pressure reduction cushion in the recliner as had been previously recommended. The narrative notes lacked indication R10 remained in recliner when not up in the EZ stand or in wheelchair, had been sleeping in her recliner, and had not slept in her bed with the pressure redistribution mattress in place since her return from the hospital on 11/20/24 The facility policy, Care plan and baseline care plan, reviewed 2/28/24, identified the policy, bullet #4, the care plan is constantly changing and is to be updated routinely in the electronic record to reflect the resident's current condition. The policy reflects under the Procedure, #3 the care plan is to be updated as needed to assure that they are an accurate reflection of the resident and their care needs.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684		1/27/25

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F 684	Continued From page 8 by: Based on document review, interview, and observation the facility failed to provide care in accordance with professional standards of practice when the facility failed to complete an assessment for use and placement of an hourglass sling used during Hoyer transfers for 3 of 3 residents (R5, R20, and R21) reviewed for accidents. Findings include: R5's annual minimum data set (MDS) dated 11/4/24 indicated, R5's was cognitively intact, dependent for transfers, and had the following diagnoses: cerebral vascular accident (CVA) (stroke), coronary artery disease (CAD) (thickening of the cardiac arteries), hypertension (HTN) (high blood pressure), diabetes (DM), hemiplegia or hemiparesis (inability to move one side of the body), and below the knee amputee. R5's care plan dated 11/15/24, indicated R5 required the assistance of two staff and a mechanical lift with a large sling for transfers. R5's medical record lacked evidence any assessment for the appropriate size, usage, application of the full body lift sling, or cognition level of the residents or appropriateness to use the sling, was completed. R20 quarterly MDS dated 9/27/24 indicated, R20 was cognitively intact, substantial-maximum assistance or dependent for transfers, and had the following diagnoses: HTN, DM, anxiety, and depression. R20's care plan last revised 12/4/24 indicated	F 684	Plan of Correction for Deficiency F684 It is the policy of Cassia Lakeside Generations to comply with the regulation cited under F684, which requires the facility to provide care in accordance with professional standards of practice. To assure continued compliance, the following plan has been put into place: _____ Corrective Actions for Affected Residents " Residents Affected: R5, R20, and R21 " Corrective Action: Ensure slings for mechanical lifts are positioned properly under the resident, appropriate assessments are completed upon admission, before beginning to use a mechanical lift and with a significant weight change. R21, R20 and R5 were re-assessed by the DON and RN managers. Appropriate size, usage in reference to the body, type of sling and cognition level was completed. In addition, R21, R5 and R20 were evaluated by an EZ Way representative (O)-E to confirm facility assessment. _____ Measures to Prevent Recurrence " Preventive Measures " All residents that require mechanical lifts for transfers were re-assessed for appropriate size, type, usage in reference to the body and cognition level. Policy will be reviewed. DON and/or designee will begin re-education to all nursing staff beginning on December 23, 2024 on the importance of proper assessment, sizing	

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F 684	Continued From page 9 R20 required the assist of one staff and the ez-stand for transfers to the commode, and the assist of two staff using a large sling and the Hoyer for transfers from the wheelchair to the bed. R20's medical record lacked evidence any assessment for the appropriate size, usage, application of the full body lift sling, or cognition level of the residents or appropriateness to use the sling, was completed. R21's annual MDS dated 10/25/24 indicated R21 was severely cognitively impaired, dependent for transfers, and had the following diagnoses: non-traumatic brain dysfunction, HTN, renal insufficiency (kidneys don't filter the blood as they should), DM, and Alzheimer's. R21's medical record lacked evidence any assessment for the appropriate size, usage, application of the full body lift sling, or cognition level of the residents or appropriateness to use the sling, was completed. On 11/22/24 at 10:52 p.m., the facility reported R21 had slipped forward and fallen from a Hoyer sling during a transfer from the wheelchair to the bed. R21's historical care plan dated 11/2/24 through 11/25/24, in place at the time of the fall indicated, R21 would use a small sling with assist of two staff and the hoyer lift. R21's current care plan last revised 11/26/24 indicated, R21 transferred with the assist of two using the Hoyer lift, with the loops of the sling to be placed at green on green.	F 684	and placement of sling during mechanical lift transfers with a special emphasis on residents with cognitive impairments or mobility limitations. _____ Monitoring and Auditing " Monitoring: " o DON and/or designee will conduct random audits of positioning for residents requiring mechanical lift transfers weekly X4 weeks and then monthly X2 months. o Results of these audits will be reviewed by the facility QAPI committee, which will determine if further monitoring or audits are necessary. _____ Responsibility and Completion " Those responsible to maintain compliance will be: The Director of Nursing, or designee, is responsible for maintain compliance. " Completion Date: January 27th, 2025	

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F 684	Continued From page 10 The Ez way Inc. Operators instructions dated 10/24/24, indicated the use of the deluxe sling, which crosses between the legs, with no mention of the full body sling or its usage and placement on the body. The Hourglass sling document date accessed 12/2/24, was provided, however it described the sling characteristics but did not discuss placement and usage in reference to the body. On 12/2/24 at 2:36 p.m., nursing assistant (NA)-E stated they had assisted in a transfer of R21 from the wheelchair to the bed on 11/22/24. NA-E stated R21 had been using an hour glass full body sling and Hoyer lift. NA-E stated the correct placement of the sling was to place the thicker top section at the shoulder or base of the neck and the lower thicker section just between the middle of the lower thigh to just above the knee joint. NA-E also stated R21 was not very verbal and had a tendency to curl up in the fetal position when transferring. During the transfer NA-E stated R21 had started to slide down and through the middle open area of the sling. NA-E stated they had attempted to hold R21's knees to guide the body and prevent the fall, however R21 slide forward and fell from the sling approximately 2-3 feet and had a small laceration to the right side of their head just above the ear, behind the hairline. NA-E confirmed at the time of R21's fall, the lower thick section was placed at the base of the buttock not at the lower thigh/upper knee joint, and R21 had slid out of the sling due to it's improper placement. On 12/2/24 at 3:44 p.m., nursing assistant (NA)-D stated they had assisted in a transfer of R21 from	F 684		

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F 684	Continued From page 11 the wheelchair to the bed on 11/22/24. NA-D stated R21 had been using an hour glass full body sling. NA-D stated the correct placement of the sling was to place the thicker top section at the shoulder or base of the neck and the lower thicker section just between the middle of the lower thigh to just above the knee joint. NA-D confirmed at the time of R21's fall, the lower thick section was placed at the base of the buttock not at the lower thigh/upper knee joint, and R21 had slid out of the sling due to it's improper placement. On 12/4/24 at 12:50 p.m., the registered nurse manager (RN)-A stated nurses were responsible, during the admission process to use the sling color coding system form to choose appropriate sling and size for the resident. The sling color coding system form only references a deluxe sling, a sling that is shaped like a U and the bottom two straps cross between the legs. The document lacked mention or measurements for use of a full body hour glass sling, which was the type of sling used during transfer/fall incident. RN-A stated they would then document the sling they had chosen in the care plan, and confirmed no formal assessment/tool was used, nor were measurements taken or documented in the chart. RN-A was unsure if another form was utilized when sizing for the hourglass sling, and stated they used the sizing chart for both slings. Furthermore, RN-A stated if a resident was confused or agitated during the assessment, staff would re-approach but there was no assessment that addressed this concern. On 12/2/24 at 4:35 p.m., the representative for EZ way Inc.(O)-E stated hour glass slings can be used for residents with contractions, amputations,	F 684		

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F 684	Continued From page 12 or who cant open their legs to use the U-shaped sling, however they would not recommend using them on someone who was confused or combative. O-E stated the appropriate placement of the sling was the top thicker area at the top of the shoulders, and the narrow section on the hips, and the lower thicker part on the thigh just above the knee. O-E stated using the improper size sling or improper placement can lead to a resident falling out of the sling. During follow-up conversation on 12/3/24 at 10:03 a.m., O-E stated they had provided the facility with training materials and in person trainings about patient safety, placement, and proper sling usage, but was unsure if they had provided them with the full-body assessment tool. On 12/2/24 at 3:37 p.m., the director of nursing (DON) stated upon admission the nurses were expected to use the manufacturer guidelines to appropriately size the slings for residents based on height and weight. The DON stated the nurse can choose which sling was used based on resident preference, or if they were confused, they choose the full body hour glass sling to prevent skin breakdown. Once chosen, the sling and size were placed in the care plan, however confirmed there was no formal assessment in place. On 12/2/24 at 6:22 p.m., DON stated their expectation for sling placement was halfway between the knee and butt. The DON stated staff had been trained via walk through demonstration of appropriate and safe placement, measurements, and they have an orientation checklist they go through with staff at the time of hire.	F 684		

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F 684	Continued From page 13 The facility EZ Way Smart lift (Hoyer) competency checklist undated, discussed the safe and proper use of the EZ Way Smart Lift. However, it did not discuss proper placement on the body with the exception of "making sure the resident is positioned in the center of the sling". On 12/5/24 at 11:38 a.m., DON stated the overall purpose of nursing assessments was to identify a change in condition, getting a history, and preventing undesirable outcomes. The DON expected assessments to be documented in the observation tab or in a progress note within point click care, to enable the facility to identify possible concerns and could go back and conduct another assessment if necessary. Lastly, the DON stated it was importance to complete assessments. If they were not documented it was not completed, and were necessary to improve the residents quality of life and prevent undesirable outcomes. The facility policy Floor-based, Full body Sling Lift use last reviewed 3/28/24, indicated residents who require the use of a mechanical lift will be assessed for the appropriate sling size on admission before beginning use of a mechanical lift and with significant weight change.	F 684		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		1/27/25

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F 812	Continued From page 14 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to date frozen items when the original packaging was opened. Additionally, the facility failed to maintain food in the original packaging to assure the packaging date remained on food items. This deficient practice had the potential to affect all 43 residents who ate food prepared from the kitchen. Findings include: During the initial kitchen tour on 12/02/24, at 1:15 p.m. , a tour was completed, accompanied by the Certified Dietary Manager (CDM)-A, and the Director of Food and Nutrition Services (DFN)-A. The following was noted: -One bag of precooked chicken, which measured approximately 12 inches by 14 inches, was not in the original packaging and lacked a date on the bag to indicate packaging date. -One bag of ravioli, measuring approximately 9 inches by 13 inches, was not in the original packaging and lacked the packaging date. -Two partial bags of chicken patties, both	F 812	F812 SS=F It is the policy of Cassia Lakeside Generations to comply with F812 To assure continued compliance, the following plan has been put into place; ¿ The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: o Food items were inspected, with any items outside of compliance being discarded. ¿ Actions taken to identify other potential residents having similar occurrences: o Inspect all food items to ensure proper label and packaging. ¿ Measures put in place to ensure deficient practice does not recur: o Mandatory education for all culinary staff on proper labeling and storing of food items. o Weekly audits will be completed for four weeks by the culinary director to ensure compliance with F812. After this time audits will be completed monthly for	

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F 812	Continued From page 15 observed to have been opened and contained approximately 1/2 package of patties, however, lacked identification as to when they were opened. -To partial bags of opened cheese curds, which were both approximately 1/2 open, however, also lacked indication as to which date it was opened. An unidentified staff member, was observed working in the freezer, and stated she was prepping the freezer for delivery tomorrow, and had removed the items from the boxes to save space. On 12/05/24 at 10:28 a.m., a follow up tour of the freezer was completed with DFN-A. At this time, the following was observed: -One open bag of onions, with approximately 1/3 of bag remaining, which lacked labeling to indicate the date opened. -One bag of mixed vegetables, with approximately 1/4 left, which lacked indication as to when they were opened. DFN-A stated the vegetables were not there yesterday, and indicated they would have to work further with education of staff as to the importance of of dating opened packages. A facility policy, Refrigerator and Freezer Storage, last review 1/12/24, identified all food in the freezer are wrapped tightly, labeled, and dated if not in the original container. Additionally, the policy also identified that leftover food items are stored in approved containers, labeled and dated.	F 812	two months. ¿ Effective implementation of actions will be monitored by: All findings from the audit will be reported to the administrator and DON. These results will be discussed during the facility QAPI meetings. ¿ The person responsible to maintain compliance is: Administrator or designee. ¿ Completion date: 1/27/2025	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		1/27/25

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F 880	Continued From page 16 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 880		

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F 880	Continued From page 17 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and documentation, the facility failed to consistently implement hand hygiene during provision of personal cares for 1 of 1 resident, R99, observed for wound care. Findings include: R99's Admission Face Sheet dated 12/5/24, identified R99's primary diagnosis as acute respiratory disease. R99's Face Sheet indicated additional diagnosis included retention of urine,	F 880	Plan of Correction for Deficiency F880 It is the policy of Cassia Lakeside Generations to comply with the regulation cited under F880, which pertains to the consistent implementation of hand hygiene during the provision of personal care. _____ _____ Corrective Action for Affected Resident " Resident R99: Resident #99 hand hygiene was not completed before	

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F 880	Continued From page 18 which required an indwelling foley catheter (a tube inserted into the bladder to allow urine to empty from the bladder into a closed urinary catheter bag). On 12/4/24 at 7:15 a.m., personal care observation was initiated for R99. R99's entrance door had a personal protective equipment door supply hanger in place. This was identified as being in place related to enhanced barrier precautions for R99. As noted on the CDC website (https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html), dated 6/20/24, enhanced barrier precautions include use of a gown and gloves during high-contact resident care with residents who are either infected or colonized with an MDRO (multi drug resistant organism-an infection resistant to many antibiotics and difficult to treat), as well as for residents with an indwelling medical device or wound regardless of MDRO colonization status. During high contact care, pathogens can transfer to staff hands and clothing. Using gowns and gloves will decrease that risk and the risk the staff will transmit the pathogen to other residents. On 12/4/24 at 7:15 a.m., nursing assistant (NA)-A and NA-B performed hand hygiene outside of R99's room, placed gowns, and gloves prior to entering the room. R99 was in bed, and resting with covers in place. Upon removal of the covers, it was noted R99 had been incontinent of stool, which had saturated the undergarment, and soiled resident down to the knees. Staff proceeded with preparation of supplies, gathering multiple towels and washcloths, undergarments, and a basin of warm, soapy water from the sink in the main portion of the room. Incontinence care	F 880	donning fresh gloves. Immediate re-education of all staff involved in the care of Resident R99 on proper hand hygiene protocols during peri cares and during wound care procedures. _____ Actions to Identify Other Potential Residents: " Surveillance of residents to ensure hand hygiene is being provided appropriately during cares and treatments started on 12/30/2024 _____ Measures to Ensure Deficient Practice Does Not Recur: " All care staff were re-educated on focusing on the importance of hand hygiene during personal care and wound care procedures starting 12/23/24 and will continue until all staff are educated. _____ Monitoring and Auditing Effective implementation of actions will be monitored by; The DON or designee will audit hand hygiene on two staff weekly X 4 weeks and then monthly X 2 months. " Results of these audits will be reviewed by the facility QAPI committee monthly. The committee will determine if further monitoring or audits are necessary based on the audit outcomes. _____ Those responsible to maintain compliance will be: The Director of Nursing, or designee, is responsible for maintain	

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F 880	Continued From page 19 for bowels was initiated first due to the level of incontinence. NA-B provided assist to reposition and support R99 in position while NA-A performed personal cleansing. While performing personal cares, it was noted R99's leg band to secure the catheter tubing was soiled and needed to be replaced. R99's dressing on buttocks was also noted to be soiled and needed replacement. Following cleansing, NA-A removed soiled gloves. Upon going to replace gloves, noted there were no gloves in the room, and opened door and obtained fresh gloves with the PPE supply on the outside of the door. NA-A placed fresh gloves on, however, failed to perform hand hygiene with either hand sanitizer outside of door, or soap and water in room. After assisting R99 to a back lying position, and having adjusted the pillow, NA-A proceeded to complete incontinence care and catheter care. It was observed during performance of cares fresh washcloths were used when others became soiled, and soiled linen was placed into laundry bin in room. NA-A used walkie talkie at bedside to request additional washcloths and a leg strap. Following use of walkie talkie twice, NA-A removed gloves and discarded them, and again obtained additional gloves from the PPE supply on outer side of the door. NA-A failed to perform hand hygiene prior to placing fresh gloves. Following placement of fresh gloves, NA-A used walkie again to request nurse to perform wound/skin care. At 7:32 a.m., after incontinence, catheter and wound care were completed by nurse NA-A and NA-B removed soiled gloves and obtained fresh gloves from the PPE caddy outside of the room, and placed fresh gloves without performing hand	F 880	compliance. _____ _____ Completion Date " The plan of correction will be fully implemented by January 27th,2025	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE GENERATIONS HEALTH CARE CENTER	439 WILLIAM AVENUE EAST DASSEL, MN 55325

(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 880	Continued From page 20 hygiene (either with hand sanitizer or soap and water). NA-A and NA-B continued with morning cares, placing compression hose, and putting catheter bag cover in place. NA-A prepared supplies for nurse, including prescription powder in the drawer, as well as protective cream. NA-A then proceeded to remove soiled gloves, and obtain new gloves from the PPE caddy from the door. Hand hygiene was not performed. New gloves were place. At 7:39 a.m. RN-B arrived gowned and gloved to complete wound/skin care. Following cares, RN-B removed her gown and gloves, and exited room carrying dressing and powder without performing hand hygiene in the room, however, surveyor did not exit room with RN-B. NA-A and NA-B proceeded to assist R99 with dressing and morning cares after wound/skin care was completed. NA-A and NA-B removed soiled gloves, and replaced gloves from the PPE caddy, however, failed to perform hand hygiene. NA-B proceeded with cleansing of the meatus and wiping down of the catheter with alcohol wipes to the junction with tubing. Following this, personal cares were completed and resident was transferred into his wheelchair with the standing lift. Upon completion of cares, gowns and gloves were removed by NA-B, and linens were bagged without gowns or gloves worn. Hand hygiene was not completed following removal of gowns and gloves, either with hand sanitizer or soap and water. R99 was assisted from room to go to the dining room. NA-A and NA-B removed gowns and	F 880		

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F 880	Continued From page 21 gloves prior to leaving the room. On 12/4/24, at 7:56 a.m., NA-A was interviewed regarding glove changes and hand hygiene, and as to how the process was performed. NA-A stated there should have been gloves in the room for use by staff with cares. NA-A stated hand hygiene was to be performed in the process of every glove change, however, did not have pocket sanitizer on her this morning. NA-A was then observed to take walkie from bedside table and place on hip. NA-A stated she was going to clean it off with a disinfectant wipe, and acknowledged walkie talkies should not be handled with soiled gloves. NA-A proceeded to wipe walkie talkie with wipe, dispose of wipe, and then washed hands. NA-A stated she was careful to open door with elbow, and not hand when obtaining gloves. NA-A stated hand sanitizer was to be used at the start of care, between dirty and clean glove changes, and at the finish of care. On 12/4/24 at 1:30 p.m., NA-B held out a bottle of hand sanitizer to surveyor and stated she did not have this in her pocket this morning, however, stated she was aware of the need to perform hand hygiene between removal of soiled gloves, before placing clean gloves. On 12/4/24 at 2:49 p.m., wound care observation was completed with RN-A. Prior to entering the room, hand hygiene was performed with hand sanitizer, followed by placement of gown and gloves for enhanced barrier precautions. RN-A received assistance of RN-D to assist with turning and reposition. Resident was positioned onto left side for provision of cares. During observation, it was noted although RN-A did change her gloves when going from a soiled task to clean (i.e.	F 880		

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F 880	Continued From page 22 removal/disposal of dressing, and cleansing of wound) she did not complete hand hygiene, either with alcohol hand cleanser or soap and water. RN-A completed wound care measurement without gloves. RN-A was not actually touching wound with measurements, but holding measuring tape up to it. Dressing placed by RN-A after measurements without gloves. Upon completion of cares, RN-A removed gown prior to exiting the room and performed hand hygiene prior to going on from cares. On 12/4/24 at 3:07 p.m., RN-A stated she was aware she should "have sanitized between glove changes." RN-A went on to state "You always wash your hands after changing gloves. It is assumed if you have gloves on you could have bodily fluids (on your hands)." On 12/4/24 at 3:44 p.m., concerns were reviewed with the director of nursing (DON). DON stated it was her expectation hand hygiene was completed prior to initiating cares, between glove changes, and upon the completion of cares. DON stated hand hygiene can be completed with hand sanitizers or with soap and water. DON stated this was important to prevent potential spread of infections. The facility policy, Infection Control, last reviewed 7/17/24, directed staff that gloves were to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, mucous membranes, feces, or contaminated items. The procedure directs to wash hands prior to placing the gloves, going on to direct staff if gloves became torn or heavily contaminated, gloves are to be changed before completing the task. The policy directs staff to	F 880		

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F 880	Continued From page 23 remove soiled/torn glove, and directed them to wash hands after. The facility policy, Hand Washing/Hand Hygiene, reviewed 7/17/24 indicated hand washing with sanitizer and hand washing with soap and water may be used interchangeably, unless hands are visibly soiled, or if working with a client that has C. Diff or Norovirus (illnesses which cause nausea and diarrhea which can be spread with contact, and are not effectively killed with alcohol based hand sanitizers). The policy identified hand washing was the single most effective way of controlling the spread of infection.	F 880		

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	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/03/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/03/2024. At the time of this survey, Lakeside Generations was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 01/03/2025

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Lakeside Generations is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1978, an addition was constructed and was determined to be of Type II(111) construction. In 1984, an addition was constructed and was determined to be of Type II(111) construction. The most recent addition was constructed in 1993 and was determined to be of Type II(111) construction.	K 000		

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K 000	Continued From page 2 Because the original building and the 3 additions met the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 44 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A	K 321		12/9/24

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K 321	Continued From page 3 a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain hazardous area enclosures per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.1, 19.3.2.1.3, 19.3.6.3.5, and 8.4.2. This deficient finding could have a isolated impact on the residents within the facility. Findings include: On 12/03/2024 between 9:00 and 11:00 AM, it was revealed by observation that the door leading to the soiled utility room in the north hallway did not latch when closed using the self-closing device. An interview with the Maintenance Director and Facility Administrator verified these deficient findings at the time of discovery.	K 321	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. K321 SS=D It is the policy of Cassia Lakeside Generations to comply with K321 To assure continued compliance, the following plan has been put into place; · The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: o 12/9/2024 the maintenance team installed a new latch on the door leading to the soiled utility room in the north hallway. The latch has been tested and has been confirmed to function properly. · Actions taken to identify other potential residents having similar occurrences: o All other doors were tested during a walkthrough on 12/3/2024 with no other	

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K 321	Continued From page 4	K 321	locations being identified as out of compliance. · Measures put in place to ensure deficient practice does not recur o Regular checks will be completed quarterly and in conjunction with the facility safety committee. A review of findings will be completed at that time. · Effective implementation of actions will be monitored by: The maintenance director will audit self-closing doors in accordance with NFPA 101 for three months to ensure continued compliance. Results of these audits will be reviewed by the facility Safety committee and QAPI committee and they will make the decision if further monitoring/audits are recommended. · The person responsible to maintain compliance is: Maintenance director or designee. · Completion date: 12/9/2024	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____	K 353		3/3/25

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K 353	Continued From page 5 c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2(5), and 5.2.2.2. These deficient finding could have an patterned impact on residents within the facility. Findings include: 1. On 12/03/2024 between 9:00 and 11:00 AM, it was revealed by observation that there was a lint covered sprinkler head in the laundry room closet. 2. On 12/03/2024 between 9:00 and 11:00 AM, it was revealed by observation that there were wires zip tied to the sprinkler pipe in the laundry area. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 353	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. K353 SS=E It is the policy of Cassia Lakeside Generations to comply with K353 To assure continued compliance, the following plan has been put into place; · The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: o 12/9/2024 the maintenance team cleaned off the sprinkler heads in the laundry room. The maintenance team also cut zip ties holding wires to sprinkler head pipe in entryway to the laundry room. · Actions taken to identify other potential residents having similar occurrences: o All other areas were examined during a walkthrough on 12/3/2024 with no other locations being identified as out of compliance. · Measures put in place to ensure	

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K 353	Continued From page 6	K 353	deficient practice does not recur: o Monthly audits will be completed for three months to ensure proper cleaning of the sprinkler heads is being completed. Results will be viewed at our QAPI and Safety Committee. o Maintenance team will review areas that contractors install new wires to ensure proper placement. · Effective implementation of actions will be monitored by: o Results of the audits will be reviewed at the facility QAPI meeting. · The person responsible to maintain compliance is: Administrator or designee. · Completion date: 3/3/2025	
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed	K 363		3/3/25

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K 363	Continued From page 7 when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.3 and 19.3.6.3.5. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/03//2024 between 9:00 and 11:00 AM , it was revealed by observation that the doors for Room 206 and for the breakroom cooridoor did not close and latch. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 363	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. K911 SS=D It is the policy of Cassia Lakeside Generations to comply with K911 To assure continued compliance, the following plan has been put into place; · The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: o 12/3/2024: The maintenance team	

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K 363	Continued From page 8	K 363	locked the electrical box in the therapy gym. · Actions taken to identify other potential residents having similar occurrences: o All other electrical boxes were examined during a walkthrough on 12/3/2024. No other concerns were noted. · Measures put in place to ensure deficient practice does not recur: o Maintenance team will be re-educated on use of electrical boxes. · Effective implementation of actions will be monitored by: The maintenance director will audit all electrical boxes each month for three months. The results will be reviewed in our QAPI and Safety Committee meetings. · The person responsible to maintain compliance is: Administrator or designee. · Completion date: 3/3/2025	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)	K 372		12/9/24

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	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/03/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE GENERATIONS HEALTH CARE CENTER	**439 WILLIAM AVENUE EAST DASSEL, MN 55325**

(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 372	Continued From page 9 Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3, 8.5.2.2, and 8.5.6.2. These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 12/03/2024 between 9:00 and 11:00 AM, it was revealed by observation that fire caulking was missing from penetrations in the smoke barrier at the west wing and east wing around the sprinkler pipe penetration. An interview with the Administrator and Maintenance Director verified these deficient findings at the time of discovery.	K 372	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. K372 SS=E It is the policy of Cassia Lakeside Generations to comply with K372 To assure continued compliance, the following plan has been put into place; · The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: o 12/9/2024 the maintenance team re-caulked all areas identified: the east wing barrier and the west wing barrier. · Actions taken to identify other potential residents having similar occurrences: o All other barrier were examined during a walkthrough on 12/3/2024 with no other locations being identified as out of compliance. · Measures put in place to ensure deficient practice does not recur: o Maintenance director will review smoke barrier locations after any contract work is complete near a barrier. · Effective implementation of actions will be monitored by: The maintenance director will audit areas	

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	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/03/2024**

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LAKESIDE GENERATIONS HEALTH CARE CENTER	**439 WILLIAM AVENUE EAST** **DASSEL, MN 55325**

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K 372	Continued From page 10	K 372	after contract work is complete and bring findings to QAPI and Safety Committee for review. · The person responsible to maintain compliance is: Administrator or designee. · Completion date: 12/9/2024	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain Electrical Systems per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 12/03/2024 between 09:00 and 11:00 AM, it was revealed that electrical panel located in the therapy room was not secured from being opened by unauthorized personnel. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 911	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. The Plan of Correction is submitted to meet requirements established by State and Federal law. K363 SS=E It is the policy of Cassia Lakeside Generations to comply with K363 To assure continued compliance, the following plan has been put into place; · The following corrective action will be done for the resident(s) found to have been affected by the deficient practice: o 12/9/2024 the maintenance team	3/3/25

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LAKESIDE GENERATIONS HEALTH CARE CENTER	**439 WILLIAM AVENUE EAST** **DASSEL, MN 55325**

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K 911	Continued From page 11	K 911	repaired the broken latch on door 206. They also repaired the automatic closer on the door to the breakroom entryway. · Actions taken to identify other potential residents having similar occurrences: o Automatic doors were tested during a walkthrough on 12/3/2024 with no other locations being identified as out of compliance. Resident rooms were tested with only one being out of compliance. · Measures put in place to ensure deficient practice does not recur: o Resident rooms will be audited monthly for three months by the maintenance team. Any doors identified as out of compliance will be repaired. · Effective implementation of actions will be monitored by: All findings will be recorded by the maintenance team and reviewed at QAPI and Safety committee. · The person responsible to maintain compliance is: Administrator or designee. · Completion date: 3/3/2025	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 26, 2024

Administrator
Lakeside Generations Health Care Center
439 William Avenue East
Dassel, MN 55325

Re: State Nursing Home Licensing Orders
Event ID: PGLF11

Dear Administrator:

The above facility was surveyed on December 2, 2024, through December 6, 2024, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

Judy Loecken, Regional Operations Supervisor
St. Cloud B District Office
Health Regulation Division
Minnesota Department of Health
4140 Thielman Lane
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00773	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE GENERATIONS HEALTH CARE CEN	439 WILLIAM AVENUE EAST DASSEL, MN 55325

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/2/24 through 12/6/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H55333939C (MN103538) H55331721C (MN102340) H55331705C (MN108552) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.	2 000		

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2 000	Continued From page 2 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.	2 000		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to date frozen items when the original packaging was opened. Additionally, the facility failed to maintain food in the original packaging to assure the packaging date remained on food items. This deficient practice had the potential to affect all 43 residents	21095	Corrected	3/3/25

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21095	Continued From page 3 who ate food prepared from the kitchen. Findings include: During the initial kitchen tour on 12/02/24, at 1:15 p.m. , a tour was completed, accompanied by the Certified Dietary Manager (CDM)-A, and the Director of Food and Nutrition Services (DFN)-A. The following was noted: -One bag of precooked chicken, which measured approximately 12 inches by 14 inches, was not in the original packaging and lacked a date on the bag to indicate packaging date. -One bag of ravioli, measuring approximately 9 inches by 13 inches, was not in the original packaging and lacked the packaging date. -Two partial bags of chicken patties, both observed to have been opened and contained approximately 1/2 package of patties, however, lacked identification as to when they were opened. -To partial bags of opened cheese curds, which were both approximately 1/2 open, however, also lacked indication as to which date it was opened. An unidentified staff member, was observed working in the freezer, and stated she was prepping the freezer for delivery tomorrow, and had removed the items from the boxes to save space. On 12/05/24 at 10:28 a.m., a follow up tour of the freezer was completed with DFN-A. At this time, the following was observed: -One open bag of onions, with approximately 1/3 of bag remaining, which lacked labeling to indicate the date opened. -One bag of mixed vegetables, with approximately 1/4 left, which lacked indication as	21095		

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21095	Continued From page 4 to when they were opened. DFN-A stated the vegetables were not there yesterday, and indicated they would have to work further with education of staff as to the importance of of dating opened packages. A facility policy, Refrigerator and Freezer Storage, last review 1/12/24, identified all food in the freezer are wrapped tightly, labeled, and dated if not in the original container. Additionally, the policy also identified that leftover food items are stored in approved containers, labeled and dated. SUGGESTED METHOD OF CORRECTION: The Dietary Manager or designee could develop, review, and/or revise policies and procedures to ensure food is stored appropriately. The Dietary Manager or designee could educate all appropriate staff on the policies and procedures. The Dietary Manager or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21095		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.	21385		3/3/25

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21385	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview and documentation, the facility failed to consistently implement hand hygiene during provision of personal cares for 1 of 1 resident, R99, observed for wound care. Findings include: R99's Admission Face Sheet dated 12/5/24, identified R99's primary diagnosis as acute respiratory disease. R99's Face Sheet indicated additional diagnosis included retention of urine, which required an indwelling foley catheter (a tube inserted into the bladder to allow urine to empty from the bladder into a closed urinary catheter bag). On 12/4/24 at 7:15 a.m., personal care observation was initiated for R99. R99's entrance door had a personal protective equipment door supply hanger in place. This was identified as being in place related to enhanced barrier precautions for R99. As noted on the CDC website (https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html), dated 6/20/24, enhanced barrier precautions include use of a gown and gloves during high-contact resident care with residents who are either infected or colonized with an MDRO (multi drug resistant organism-an infection resistant to many antibiotics and difficult to treat), as well as for residents with an indwelling medical device or wound regardless of MDRO colonization status. During high contact care, pathogens can transfer to staff hands and clothing. Using gowns and gloves will decrease that risk and the risk the staff will transmit the pathogen to other residents.	21385	Corrected	

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21385	Continued From page 6 On 12/4/24 at 7:15 a.m., nursing assistant (NA)-A and NA-B performed hand hygiene outside of R99's room, placed gowns, and gloves prior to entering the room. R99 was in bed, and resting with covers in place. Upon removal of the covers, it was noted R99 had been incontinent of stool, which had saturated the undergarment, and soiled resident down to the knees. Staff proceeded with preparation of supplies, gathering multiple towels and washcloths, undergarments, and a basin of warm, soapy water from the sink in the main portion of the room. Incontinence care for bowels was initiated first due to the level of incontinence. NA-B provided assist to reposition and support R99 in position while NA-A performed personal cleansing. While performing personal cares, it was noted R99's leg band to secure the catheter tubing was soiled and needed to be replaced. R99's dressing on buttocks was also noted to be soiled and needed replacement. Following cleansing, NA-A removed soiled gloves. Upon going to replace gloves, noted there were no gloves in the room, and opened door and obtained fresh gloves with the PPE supply on the outside of the door. NA-A placed fresh gloves on, however, failed to perform hand hygiene with either hand sanitizer outside of door, or soap and water in room. After assisting R99 to a back lying position, and having adjusted the pillow, NA-A proceeded to complete incontinence care and catheter care. It was observed during performance of cares fresh washcloths were used when others became soiled, and soiled linen was placed into laundry bin in room. NA-A used walkie talkie at bedside to request additional washcloths and a leg strap. Following use of walkie talkie twice, NA-A removed gloves and discarded them, and again	21385		

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21385	Continued From page 7 obtained additional gloves from the PPE supply on outer side of the door. NA-A failed to perform hand hygiene prior to placing fresh gloves. Following placement of fresh gloves, NA-A used walkie again to request nurse to perform wound/skin care. At 7:32 a.m., after incontinence, catheter and wound care were completed by nurse NA-A and NA-B removed soiled gloves and obtained fresh gloves from the PPE caddy outside of the room, and placed fresh gloves without performing hand hygiene (either with hand sanitizer or soap and water). NA-A and NA-B continued with morning cares, placing compression hose, and putting catheter bag cover in place. NA-A prepared supplies for nurse, including prescription powder in the drawer, as well as protective cream. NA-A then proceeded to remove soiled gloves, and obtain new gloves from the PPE caddy from the door. Hand hygiene was not performed. New gloves were place. At 7:39 a.m. RN-B arrived gowned and gloved to complete wound/skin care. Following cares, RN-B removed her gown and gloves, and exited room carrying dressing and powder without performing hand hygiene in the room, however, surveyor did not exit room with RN-B. NA-A and NA-B proceeded to assist R99 with dressing and morning cares after wound/skin care was completed. NA-A and NA-B removed soiled gloves, and replaced gloves from the PPE caddy, however, failed to perform hand hygiene. NA-B proceeded with cleansing of the meatus and wiping down of the catheter with alcohol wipes to the junction with tubing. Following this, personal cares were completed and resident was transferred into his wheelchair with the standing	21385		

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LAKESIDE GENERATIONS HEALTH CARE CEN	439 WILLIAM AVENUE EAST DASSEL, MN 55325

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21385	Continued From page 8 lift. Upon completion of cares, gowns and gloves were removed by NA-B, and linens were bagged without gowns or gloves worn. Hand hygiene was not completed following removal of gowns and gloves, either with hand sanitizer or soap and water. R99 was assisted from room to go to the dining room. NA-A and NA-B removed gowns and gloves prior to leaving the room. On 12/4/24, at 7:56 a.m., NA-A was interviewed regarding glove changes and hand hygiene, and as to how the process was performed. NA-A stated there should have been gloves in the room for use by staff with cares. NA-A stated hand hygiene was to be performed in the process of every glove change, however, did not have pocket sanitizer on her this morning. NA-A was then observed to take walkie from bedside table and place on hip. NA-A stated she was going to clean it off with a disinfectant wipe, and acknowledged walkie talkies should not be handled with soiled gloves. NA-A proceeded to wipe walkie talkie with wipe, dispose of wipe, and then washed hands. NA-A stated she was careful to open door with elbow, and not hand when obtaining gloves. NA-A stated hand sanitizer was to be used at the start of care, between dirty and clean glove changes, and at the finish of care. On 12/4/24 at 1:30 p.m., NA-B held out a bottle of hand sanitizer to surveyor and stated she did not have this in her pocket this morning, however, stated she was aware of the need to perform hand hygiene between removal of soiled gloves, before placing clean gloves.	21385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00773	A. BUILDING: _____ B. WING _____	C 12/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21385	Continued From page 9 On 12/4/24 at 2:49 p.m., wound care observation was completed with RN-A. Prior to entering the room, hand hygiene was performed with hand sanitizer, followed by placement of gown and gloves for enhanced barrier precautions. RN-A received assistance of RN-D to assist with turning and reposition. Resident was positioned onto left side for provision of cares. During observation, it was noted although RN-A did change her gloves when going from a soiled task to clean (i.e. removal/disposal of dressing, and cleansing of wound) she did not complete hand hygiene, either with alcohol hand cleanser or soap and water. RN-A completed wound care measurement without gloves. RN-A was not actually touching wound with measurements, but holding measuring tape up to it. Dressing placed by RN-A after measurements without gloves. Upon completion of cares, RN-A removed gown prior to exiting the room and performed hand hygiene prior to going on from cares. On 12/4/24 at 3:07 p.m., RN-A stated she was aware she should "have sanitized between glove changes." RN-A went on to state "You always wash your hands after changing gloves. It is assumed if you have gloves on you could have bodily fluids (on your hands)." On 12/4/24 at 3:44 p.m., concerns were reviewed with the director of nursing (DON). DON stated it was her expectation hand hygiene was completed prior to initiating cares, between glove changes, and upon the completion of cares. DON stated hand hygiene can be completed with hand sanitizers or with soap and water. DON stated this was important to prevent potential spread of infections. The facility policy, Infection Control, last reviewed	21385		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21385	Continued From page 10 7/17/24, directed staff that gloves were to be worn whenever there may be direct contact between the caregiver's hands and blood, body fluids, mucous membranes, feces, or contaminated items. The procedure directs to wash hands prior to placing the gloves, going on to direct staff if gloves became torn or heavily contaminated, gloves are to be changed before completing the task. The policy directs staff to remove soiled/torn glove, and directed them to wash hands after. The facility policy, Hand Washing/Hand Hygiene, reviewed 7/17/24 indicated hand washing with sanitizer and hand washing with soap and water may be used interchangeably, unless hands are visibly soiled, or if working with a client that has C. Diff or Norovirus (illnesses which cause nausea and diarrhea which can be spread with contact, and are not effectively killed with alcohol based hand sanitizers). The policy identified hand washing was the single most effective way of controlling the spread of infection. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure infection control procedures and standards are maintained by all staff as appropriate. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21385		