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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QG8G
Facility ID: 00682

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/23/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

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

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

* Code: A (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 10/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 11/04/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245388

November 4, 2015

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

Dear Mr. Corchran:

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

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

Effective October 9, 2015 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
November 4, 2015

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

RE: Project Number S5388026

Dear Mr. Corchran:

On October 2, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 17, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 23, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 21, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 9, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 17, 2015, effective October 9, 2015 and therefore remedies outlined in our letter to you dated October 2, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245388	A. Building B. Wing	10/23/2015

Name of Facility	Street Address, City, State, Zip Code
LAKESHORE INN NURSING HOME	108 8TH STREET NORTHWEST WASECA, MN 56093

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	**10/09/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**10/09/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	**10/09/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	**10/09/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	11/04/2015	03048	10/23/2015
CMS RO				

Followup to Survey Completed on: 9/17/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245388	01 - MAIN BUILDING 01	10/21/2015

Name of Facility	Street Address, City, State, Zip Code
LAKESHORE INN NURSING HOME	108 8TH STREET NORTHWEST WASECA, MN 56093

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0038	09/28/2015	ID Prefix Reg. # NFPA 101 LSC K0154	09/25/2015	ID Prefix Reg. # NFPA 101 LSC K0155	09/25/2015
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	TL/kfd	11/04/2015	34764	10/21/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 9/15/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: QG8G
Facility ID: 00682

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

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

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

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/17/2015** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10. THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lois Boerboom, HFE NE II 10/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/27/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

25. LTC EXTENSION DATE:
(L27)

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 2, 2015

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

RE: Project Number S5388026

Dear Mr. Corchran:

On September 17, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Kathryn.serie@state.mn.us
Office: (507) 476-4233Fax: (507) 537-7194

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 27, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 27, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

• Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by December 17, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 17, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Gary Schroeder, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
gary.schroeder@state.mn.us
Telephone: (507) 361-6204

Feel free to contact me if you have questions.
Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245388	A. BUILDING ______ B. WING ______	09/17/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure an individualized activity program was implemented for 2 of 5 residents (R31 & R30) reviewed for activities. Findings include: R31 had diagnoses identified on the electronic medical record (EMR) list including: Mental disorder (dementia); Meniere's disease; osteoporosis; hypertension; delirium and	F 248	Activities meeting interest/needs of resident R31's care plan have been reviewed. Changes in approach include: Encourage CNA's to inform resident of daily activities and allow her choice of activity or nap (activity staff will continue to provide reminders as well but if resident is already in bed asleep, it will be difficult to get her out to the activity). Activity staff will provide 1-1 visits - music, conversation, update from daily papers, bible reading/devotional - if resident is not	10/9/15

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

Electronically Signed | | 10/12/2015

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

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	245388	A. BUILDING ______ B. WING ______	09/17/2015

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

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F 248 Continued From page 1

paranoia.

The annual Minimum Data Set (MDS) assessment dated 9/14/15, indicated the resident had severe cognitive impairment. The MDS preferences for customary routine and activities dated 9/3/15 indicated:
(1.) Very important activity preferences as listening to music; doing favorite activities and participating in religious services or practices;
(2.) Somewhat important as keeping up with the news; do things with groups of people; go outside to get fresh air when the weather is good
(3.) Not very important were having books, newspapers, and magazines to read, and be around animals such as pets.

The annual therapeutic recreation progress report with the assessment reference date of 9/1/15-9/7/15 indicated:
(1) Social interactions: initiates conversations; at ease doing planned or structured activities; at ease doing self initiated activities; prefers to rest in room; spends most of time in room;
(2) Physical mental and psychosocial heath as extremity function affected; range of motion affected; hand dexterity affected; ability to manipulate item affected; dementia and hallucinations continue remains difficult to redirect;
(3) Cognitive/memory as confused, memory loss affects function; unable to maintain attention and easily distracted;
(4) Behaviors of anxiety and hallucinations;
(5) Communication/ comprehension as sometimes understands others; sometimes makes self understood and needs known; speech unclear and difficult to understand;
(6) Hearing is functional/adequate;

F 248

meeting weekly goals. Activity staff will provide manicures upon request. Care plans will be placed in daily documentation book for easy reference. CNA's will be informed of new approach through communication book on wing.

R30's care plan has been reviewed. The following changes have been made after visiting with resident about current approaches. We have removed from the care plan the following: prefers solitary activities, provide time outdoors and include pet visits. Remove bingo and food and fellowship from most attended list. Expand 1-1 visit approach to include music, conversation, update from daily newspapers, bible/devotional reading if resident is not meeting group attendance goals. Add approach of manicures upon request. Add approach of encourage morning activities as resident prefers to rest on her bed in the afternoon. Add approach of CNA's will encourage resident to attend activities. (Activity staff will continue to invite and inform also). Care plans will be placed in daily documentation book for easy reference. CNA's will be informed of new approach through communication book on wing.

The activity director will place care plans for each resident in daily documentation book so all activity staff is aware of current goals and approaches.

The activity director will review other care plans to monitor if needs and interest of residents are being met. She will review 5

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F 248	Continued From page 2 (7) Vision: Able to find bingo numbers (8) Mobility requires escort in wheelchair; (9) Adaptations needed for activity participation include: escort; 1-1 assist and redirection for behaviors. R31's activity care plan dated 9/8/15, indicated a potential for withdrawal from leisure pursuits of interest related to physical debility, mental debility, impaired communication (very difficult to understand) and indicators of anxiety. Approaches included: (1) invite to activities, (2) assist to activities, (3) provide schedule of events and (3) provide 1:1 assist as needed to enhance participation. Most often attends: religious programming, musical programming, Bingo, morning mix and exercises, special events, reading group, movies, popcorn, work games and trivia, food and fellowship. Update activity preferences as changes occur. Offer reassurance when resident is delusional or having episodes of high anxiety, and to inform nursing of such episodes. Activity/recreation note indicated R31 attended : 3-6 group activities per week; and special leisure interests including bingo, religious programs and musical programs; TV in room; manicures and family visits. On 9/16/15, at 8:04 a.m. R31 was observed in the geri chair in her room after morning cares were provided. At 9:00 a.m. it was noted that R31 had been transported from her room to the dining room and staff were assisting her with the breakfast meal. At 9:03 a.m. R31 was transported in the geri-chair from the dining room to her room and the television was turned on. At 9:26 a.m. R31 had been transferred back into	F 248	care plans and assessments each week, comparing with documentation sheets to determine if residents are attending activities they have interest in. This will be done for 4 weeks. Then 5 care plans and assessments will be reviewed every 2 weeks for 2 months. Finally, 5 care plans and assessments will be reviewed monthly for 3 months. The results will be shared with the QA committee at their quarterly meetings.	

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F 248	Continued From page 3 bed and was asleep. According to the activity calendar- Spa Morning (hand soak and massage) was scheduled to begin at 10:00 a.m. No staff were observed asking R31 to attend this activity even though it had been documented she had attended in the past. R31 remained asleep in bed until 11:24 a.m. (2 hours). At 11:50 a.m. staff transferred R31 from the bed to her geri-chair prior to the noon meal. When interviewed on 9/16/15, at 11:54 a.m. trained medication aide (TMA)-A verified R31 used to attend activities a lot but doesn't anymore and spends most of her time in bed. It was observed on 9/16/15, at 2:01 p.m. that R31 remained lying on her bed with eyes open, moving her arms. According to the activity calendar, Bingo was scheduled at 2:00 p.m. and R31 remained in her room. No staff were observed asking R31 to attend this group activity. The plan of care indicated R31 often attended Bingo. When interviewed on 9/16/15, at 2:25 p.m. nursing assistants (NA)-D and NA-E stated R31 used to attend all the scheduled activities but doesn't do much anymore. They indicated R31 attends music and church events and enjoys manicures. NA-D indicated R31's family does visit occasionally, but R31 is seldom outside of her room. On 9/17/15, at 8:18 a.m. R31 was seated in her geri chair in the dining room while being fed breakfast. At 9:00 a.m. R31 was transported back to her room via the geri chair. At 9:27 a.m. R31 remained in her room seated in the geri chair with the television turned on. At 10:28 am. R31	F 248		

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F 248	Continued From page 4 was observed lying in bed, during an activity when a choir performed for residents. There was no observation that R31 had been invited to attend this musical activity. According to the plan of care, R31 enjoyed musical programs. When interviewed on 9/17/15, at 12:29 p.m. licensed practical nurse (LPN)-B stated R31 often just attends morning activities as she likes to lie down and rest in the afternoon. She further stated that R31 enjoys church and music activities. On 9/17/15, at 2:08 p.m. the activity director (AD) was interviewed and indicated R31's level of socialization wasn't very high as she spends most of the day in bed. The AD further indicated R31 had previously attended many activities; however, since her paranoia had increased she hadn't been attending many. The AD indicated R31 will occasionally participate in singing but also enjoyed the special entertainment programs. The AD indicated she spent time with residents who do not get out for a lot of activities, just visiting, but acknowledged she did not keep a record of these types of informal visits. When questioned about individual 1:1 activities for dependent residents, the AD responded manicures were done on 9/16/15, and 15 residents had received manicures and hand soaks. The AD stated, "there are only so many residents that can be done" and verified that R31 had participated by having a manicure in the past but "there wasn't time for her yesterday" (9/16/15) at the 10:00 a.m. manicure. The AD confirmed R31 had previously attended "Spa Morning" when offered in August of this year. In addition, the AD confirmed R31 had not attended the choir activity which had occurred at 10:00 a.m. that morning.	F 248		

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F 248	Continued From page 5 The AD indicated the Bingo activity on 9/16/15, at 2:00 p.m. was not offered to R31. She stated R31 had been "in bed and they don't bother her then". The AD further indicated she thought the nursing assistants contacted residents to invite them to attend activities. She stated staff made an effort to involve R31 but, "as her moods and behaviors increased it made it difficult for her [R31] to attend". The AD then stated, "This wasn't a good week to see people involved as we can only do so much." R30 had diagnoses obtained from the electronic medical record's Diagnoses List which included: Alzheimer's disease, Diabetes type II; osteoarthrosis, depressive disorder and hypertension. The most recent quarterly assessment dated 8/4/15, indicated a Brief Interview for Mental Status (BIMS) score of 4 of 15 which indicated severe cognitive impairment and documented that R30 was dependent for locomotion on/off the unit and independent with eating after set up. A PHQ-9 (assessment for determining the presence of depression) indicated score of 00/27, which indicated no depression. Review of the care plan dated 5/4/15 listed the following: Problem: potential for withdrawal from leisure pursuits related to (R/T) physical and mental debility. Little or no social interaction: Passively participates in activities. Interventions included: (1) identify interests; (2) Identify strengths and limitations invite to activities; (3) Assist to activities; (4) Involve family; (5) Provide 1:1 activities; (6) Prefers solitary activities; (7) Prefers group activities (musical). (8) Provide time outdoors as weather permits, Include in pet visits; (9) Provide schedule of events; and (10)	F 248		

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F 248	Continued From page 6	F 248		

Provide 1:1 visits as tolerated, respect resident's right to limited social interaction. Problem dated 2/2/15, Focus: resident is dependent on staff for activities, cognitive stimulation, social interaction R/T Dx of dementia evidenced by (E/B) inability to choose own leisure time activities. Interventions include: Resident's preferred activities are: Lutheran worship services, devotions, bingo, entertainment, watching TV, visiting with family, dining with family, baking group, reading group and small groups.

During observation on 9/15/15, at 6:12 p.m. R30 finished the evening meal in the dining room and was then transported back to her room, where she remained seated in her wheelchair(w/c) with her back toward the window and facing the door which opened into the hallway. R30 remained in her room without any TV and/or radio on until 6:45 p.m. when nursing assistant (NA)-B entered R30's room and provided a bedtime (HS) snack. NA-B spoke with R30 and told her she would return after she had eaten her snack to assist her in getting ready for bed. Staff did not offer R30 to participate in the evening reading group at 6:00 p.m. in the activity room located near the dining room following the supper meal. According to the plan of care, R30's preferred activity included a reading group.

It was observed on 9/16/15, at 9:00 a.m. that upon completion of the breakfast meal, the beautician transported R30 to the beauty shop. At 9:47 a.m. R30 was transported from the beauty shop to the main lounge area where she was left with other residents located in the area in front of the TV. During this time R30 did not display interest in the TV program. At 9:56 a.m. the activity director (AD) approached R30 and

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F 248	Continued From page 7	F 248		

asked whether she wanted to attend the scheduled activity (Spa morning) in the dining room starting at 10:00 a.m. R30 stated, "no" and the AD walked away. No additional attempts were made to encourage R30 to attend or observe the morning activity. R30 continued to sit in the same location in front of the TV until 10:45 a.m. (1 hour later) when she was transported to her room by NA-C for check/change prior to dinner.

On 9/16/15, at 1:00 p.m. R30's family member (FM)-A was observed visiting with R30. FM-A indicated he visits on a daily basis, has a noon meal with his wife and stays visiting with her until staff lay her down for an afternoon rest. FM-A indicated he had visited with various facility staff about his desire for R30 to receive more stimulation and attend activity programs when she was not napping. FM-A clarified that R30 will always say "no" when asked to attend any activity as she didn't understand what was being asked due to her dementia.

During an interview on 9/15/15, at 6:44 p.m. NA-A stated R30 does not attend activities as she likes to sleep. NA-A acknowledged FM-A stated he desired R30 to be out of bed more but indicated R30 was always lying down when she arrived at work (2:30 p.m.). NA-A confirmed activities would be taking place at that time, however R30 did not routinely attend. NA-A indicated she was not aware whether R30 was offered the opportunity to attend those early afternoon activities as they are already in progress when she gets to work, and R30 is usually in her room. NA-A further clarified that R30 remains in bed until about 4:15 p.m. when she is gotten up from her nap and usually

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F 248	Continued From page 8 remains in her room until being transported to the dining room for the evening meal. NA-A further stated there was no music nor TV turned on in R30's room for enjoyment/stimulation during this time. NA-A stated R30 does appear to enjoy looking out the window. NA-A stated R30 doesn't respond when invited to activities, or asked about cares, rather R30 frequently just looks at the person without any response. NA-B was interviewed on 9/15/15, at 6:51 p.m. and also verified R30 does not attend activities during the afternoon shift. NA-B further stated since R30 had been a resident the TV may be turned on maybe 1-2 times, that she was aware. NA-B stated that if R30 is turned toward the window facing the lake she will look outside but otherwise R30 remains seated in the w/c. NA-B confirmed that R30 is unable to move her wheelchair without staff assistance and indicated that she thought "if [R30] was allowed to remain in bed she would remain there 24/7". LPN-A who was also in attendance confirmed this statement. During an interview on 9/16/15, at 2:22 p.m. co-director of nursing (CDON)-A confirmed R30 doesn't usually attend activities in the afternoon as she rests after the noon meal. CDON-A further confirmed FM-A had spoken with staff r/t having R30 attend activities so they do attempt to have R30 attend music and other group activities. On 9/16/15, at 3:28 p.m. the activity director (AD) stated R30 lies down in the afternoon for a nap and so attempts are made to have R30 involved in morning activities. The AD further stated she was aware FM-A would like to have R30 attend more activities but R30 will refuse; but clarified that if R30 refuses, when approached by another	F 248		

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F 248	Continued From page 9 staff who offers to take her to an activity, at times, R30 will agree. AD indicated this had not occurred during the past two days. The AD confirmed that currently there were no 1:1 activities offered to R30 and did not verbalize any rationale for not providing any. The AD further stated it was difficult to say whether a 1:1 activity would be beneficial as R30 is passive when attending an activity. Review of the activity logs for July - September 2015 indicated R30 did not participate in afternoon and evening activities. During a subsequent interview on 9/17/15, at 8:58 a.m. the AD stated she was not providing 1:1 activity as she felt R30 was meeting her goal and so it was not necessary. She stated it was difficult to determine whether a 1:1 activity would be beneficial as R30 is passive when attending an activity. The AD stated when R30 attends a group activity, she will sit and look but doesn't offer participation most of the time. Review of the facility's Patient Activities Policy dated 1982, indicated-"Purpose: The purpose of the activity's program in this nursing home is to meet needs and interests of each individual resident through purposeful activity. Policy: It is the policy of this nursing home to have an organized activity program staffed and equipped to assess and to meet needs and interests of each individual resident through purposeful activities. Responsibility: A qualified Activities Coordinator is responsible for the planning, implementation and supervision of the activities program."	F 248		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		10/9/15

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F 282	Continued From page 10 The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care related to activity programing for 2 of 5 residents (R31 & R30) reviewed for activities. Findings include: R31 had diagnoses identified on the electronic medical record (EMR) diagnoses list including: Mental disorder (dementia); Meniere's disease; osteoporosis; hypertension; delirium and paranoia. R31's activity care plan dated 9/8/15, indicated a potential for withdrawal from leisure pursuits of interest related to physical debility, mental debility, impaired communication (very difficult to understand) and indicators of anxiety. Approaches included: (1) invite to activities, (2) assist to activities, (3) provide schedule of events and (3) provide 1:1 assist as needed to enhance participation. Most often attends: religious programming, musical programming, bingo, morning mix and exercises, special events, reading group, movies, popcorn, work games and trivia, food and fellowship. Update activity preferences as changes occur. Offer reassurance when resident is delusional or having episodes of high anxiety. Inform nursing of episodes.	F 282	Activities meeting interest/needs of resident R31's care plan have been reviewed. Changes in approach include: Encourage CNA's to inform resident of daily activities and allow her choice of activity or nap (activity staff will continue to provide reminders as well but if resident is already in bed asleep, it will be difficult to get her out to the activity). Activity staff will provide 1-1 visits - music, conversation, update from daily papers, bible reading/devotional - if resident is not meeting weekly goals. Provide manicures upon request. Remove reading group from most often attends. Add - return to room if resident becomes anxious during activity and cannot be redirected. Care plan will be placed in daily documentation book for easy reference by activity staff. CNA's will be informed of new approach through communication book. R30's care plan has been reviewed. The following changes have been made after visiting with resident about current approaches. We have removed from the care plan the following: prefers solitary activities, provide time outdoors and include pet visits. Remove bingo and food and fellowship from usually attends list.	

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F 282	Continued From page 11 Activity/recreation notes indicated R31 attended : 3-6 group activities per week; and special leisure interests including bingo, religious programs and musical programs; TV in room; manicures and family visits. On 9/16/15, at 8:04 a.m. R31 was observed in the geri chair in her room after morning cares were provided. At 9:00 a.m. it was noted that R31 had been transported from her room to the dining room and staff were assisting her with the breakfast meal. At 9:03 a.m. R31 was transported in the geri-chair from the dining room to her room and the television was turned on. At 9:26 a.m. R31 had been transferred back into bed and was asleep. According to the activity calendar- Spa Morning (hand soak and massage) was scheduled to begin at 10:00 a.m. No staff were observed asking R31 to attend this activity even though it had been documented she had attended in the past. R31 remained asleep in bed until 11:24 a.m. (2 hours). At 11:50 a.m. staff transferred R31 from the bed to her geri-chair prior to the noon meal. When interviewed on 11/16/15, at 11:54 a.m. trained medication aide (TMA)-A indicated R31 used to attend activities a lot but doesn't anymore and spends most of her time in bed. It was observed on 9/16/15, at 2:01 p.m. that R31 remained lying on her bed with eyes open, moving her arms. According to the activity calendar, Bingo was scheduled at 2:00 p.m. and R31 remained in her room. No staff were observed asking R31 to attend this group activity. The plan of care indicated R31 often attended Bingo.	F 282	Expand 1-1 visit approach to include music, conversation, update from daily newspapers, bible/devotional reading if resident is not meeting group attendance goals. Add approach of manicures upon request. Add approach of encourage morning activities as resident prefers to rest on her bed in the afternoon. Add approach of CNA's will encourage resident to attend activities. (Activity staff will continue to invite and inform also). Care plans will be placed in daily documentation book for easy reference. CNA's will be informed of new approach through communication book on wing. The activity director will place care plans for each resident in daily documentation book so all activity staff is aware of current goals and approaches. The activity director will review other care plans to monitor if needs and interest of residents are being met. She will review 5 care plans and assessments each week, comparing with documentation sheets to determine if residents are attending activities they have interest in. This will be done for 4 weeks. Then 5 care plans and assessments will be reviewed every 2 weeks for 2 months. Finally, 5 care plans and assessments will be reviewed monthly for 3 months. The results will be shared with the QA committee at their quarterly meetings.	

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F 282	Continued From page 12	F 282		

When interviewed on 9/16/15, at 2:25 p.m. nursing assistants (NA)-D and NA-E stated R31 used to attend all the scheduled activities but doesn't do much anymore. They indicated R31 attends music and church events and enjoys manicures. NA-D indicated R31's family does visit occasionally, but R31 is seldom outside of her room.

On 9/17/15, at 8:18 a.m. R31 was seated in her geri chair in the dining room while being fed breakfast. At 9:00 a.m. R31 was transported back to her room via the geri chair. At 9:27 a.m. R31 remained in her room seated in the geri chair with the television turned on. At 10:28 am. R31 was observed lying in bed while a choir provided the morning scheduled activity. There was no observation that R31 had been invited to attend this musical activity. According to the plan of care, R31 enjoyed musical programming.

When interviewed on 9/17/15, at 12:29 p.m. licensed practical nurse (LPN)-B stated R31 often just attends morning activities as she likes to lie down and rest in the afternoon. She further stated that R31 enjoys church and music activities.

On 9/17/15, at 2:08 p.m. the activity director (AD) was interviewed and indicated R31's level of socialization wasn't very high as she spends most of the day in bed. The AD further indicated R31 had previously attended many activities; however, since her paranoia had increased she hadn't been attending many activities. The AD indicated R31 will occasionally participate in singing but also enjoys the special entertainment programs. The AD further stated she had

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F 282	Continued From page 13 contacts with residents who do not get out for a lot of activities and even when she isn't doing an activity she just visits, but does not document this visit. When questioned about individual 1:1 activities for dependent residents, the AD responded manicures were done on 9/16/15, and 15 residents received manicures and hand soaks. The AD stated, "there are only so many residents that can be done" and verified that R31 had manicures in the past but there wasn't time for her yesterday (9/16/15) at the 10:00 a.m. manicure. The AD confirmed R31 had previously attended "Spa Morning" when offered in August. In addition, the AD confirmed the choir activity occurred at 10:00 a.m. that morning and R31 had not been in attendance. The AD indicated the Bingo activity on 9/16/15, at 2:00 p.m. was not offered stating, [R31] "was in bed and they don't bother her then". The AD further indicated she thought the nursing assistants contacted residents to invite them to attend the activities. She stated R31's plan of care had not been updated and that staff made an effort to involve R31 but, "as her moods and behaviors increased it made it difficult for her to attend". The AD then stated, "This wasn't a good week to see people involved as we only can do so much". R30 had diagnoses obtained from the electronic medical record Diagnoses List which included: Alzheimer's disease, Diabetes type II; osteoarthrosis, depressive disorder and hypertension. The most recent quarterly assessment dated 8/4/15, indicated a Brief Interview for Mental Status (BIMS) score of 4 of 15 which indicated severe cognitive impairment and documented that R30 was dependent for locomotion on/off the	F 282		

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F 282	Continued From page 14	F 282		

unit.
Review of the care plan dated 5/4/15 listed the following: Problem: potential for withdrawal from leisure pursuits related to (R/T) physical and mental debility. Little or no social interaction: Passively participates in activities. Interventions included: (1) identify interests; (2) Identify strengths and limitations invite to activities; (3) Assist to activities; (4) Involve family; (5) Provide 1:1 activities; (6) Prefers solitary activities; (7) Prefers group activities (musical). Provide time outdoors as weather permits, Include in pet visits. Provide schedule of events, Provide 1:1 visits as tolerated, respect resident's right to limited social interaction. Problem dated 2/2/15, Focus: resident is dependent on staff for activities, cognitive stimulation, social interaction R/T Dx of dementia evidenced by (E/B) inability to choose own leisure time activities. Interventions include: Resident's preferred activities are: Lutheran worship services, devotions, bingo, entertainment, watching TV, visiting with family, dining with family, baking group, reading group and small groups.
During observation on 9/15/15, at 6:12 p.m. R30 finished the evening meal in the dining room and then was transported back to her room, where she remained seated in her wheelchair(w/c) with her back toward the window and facing the door which opened into the hallway. R30 remained in her room without any TV and/or radio on until 6:45 p.m. when nursing assistant (NA)-B entered R30's room and provided a bedtime (HS) snack. NA-B spoke with R30 and told her she would return after she had eaten her snack to assist her in getting ready for bed. Staff did not offer R30 to participate in the evening reading group at 6:00 p.m. According to the plan of care, R30's preferred activity included a reading group.

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F 282	Continued From page 15 During observation on 9/16/15, at 9:47 a.m. R30 was transported from the beauty shop to the main lounge area where she was left with other residents in front of the TV. It was noted that R30 looked around the room and then down at her lap. R30 glanced toward the TV and then back down at her lap. During this time R30 did not display interest in the TV program. At 9:56 a.m. the activity director (AD) approached R30 and asked whether she wanted to attend the scheduled activity (Spa morning) in the dining room starting at 10:00 a.m. R30 stated, "no" and the AD walked away. No additional attempts were made to encourage R30 to attend or observe the morning activity. R30 continued to sit looking down, displaying no interest in the current TV program. No staff interaction with R30 other than "good morning" was observed as staff persons walked past. R30 continued to sit in the same location in front of the TV until 10:45 a.m. (1 hour later) when she was transported to her room by NA-C for check/change prior to dinner. On 9/16/15, at 1:00 p.m. R30's family member (FM)-A was observed visiting with R30. FM-A indicated he visits on a daily basis, has a noon meal with his wife and stays visiting with her until staff lay her down for an afternoon rest. FM-A indicated he had visited with various facility staff about his desire for R30 to receive more stimulation and attend activity programs when she was not napping. FM-A clarified that R30 will always say "no" when asked to attend any activity as she didn't understand what was asked due to her dementia. During an interview on 9/15/15, at 6:44 p.m. NA-A stated R30 does not attend activities as she likes to sleep. NA-A indicated FM-A stated he desired R30 to be out of bed more but indicated R30 was always lying down when she arrived at	F 282		

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F 282	Continued From page 16 work (2:30 p.m.) NA-A confirmed activities were taking place at this time but R30 did not routinely attend. NA-A indicated she was not aware whether R30 was offered attendance in activities as they are already in progress when R30 is in her room. NA-A further clarified that R30 remains in bed until about 4:15 p.m. when she is gotten up from her nap and usually remains in her room until being transported to the dining room for the evening meal. NA-A indicated there was no music nor TV turned on in R30's room for enjoyment/stimulation during this time. NA-A indicated that R30 doesn't offer input regarding cares or activities as when asked R30 will frequently just look at the person and not respond. NA-B was interviewed on 9/15/15, at 6:51 p.m. and indicated R30 does not attend activities during the afternoon shift. NA-B further indicated since R30 has been a resident the TV may be turned on maybe 1-2 times, that she was aware. NA-B stated that if R30 is turned toward the window facing the lake she will look outside but otherwise R30 remains seated in the w/c. NA-B confirmed that R30 is unable to move her wheelchair without staff assistance and indicated that she thought "if [R30] was allowed to remain in bed she would remain there 24/7". LPN-A who was also in attendance confirmed this statement. During an interview on 9/16/15, at 2:22 p.m. co-director of nursing (CDON)-A confirmed R30 doesn't usually attend activities in the afternoon as she rests after the noon meal. CDON-A further confirmed FM-A had spoken with staff r/t having R30 attend activities so they do attempt to have R30 attend music and other group activities. On 9/16/15, at 3:28 p.m. the activity director (AD) stated R30 lies down in the afternoon for a nap and so attempts are made to have R30 involved	F 282		

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F 282	Continued From page 17 in morning activities. The AD further stated she was aware FM-A would like to have R30 attend more activities but R30 will refuse; but clarified that if R30 refuses, when approached by another staff who offers to take her to an activity, at times, R30 will agree. AD indicated this had not occurred during the past two days. The AD confirmed that currently there were no 1:1 activities offered to R30 and did not verbalize any rationale for not providing any. The AD further stated it was difficult to say whether a 1:1 activity would be beneficial as R30 is passive when attending an activity. Review of the activity logs for July - September 2015 indicated R30 was in attendance during morning group activities several days per week, but there were few activities (only 1-2) documented at times other than morning. These activities coincided with R30 in attendance with FM-A. Review of the facility Patient activities policy dated 1982 indicated-Purpose: The purpose of the activities program in this nursing home is to meet needs and interests of each individual resident through purposeful activity. Policy: It is the policy of this nursing home to have an organized activities program staffed and equipped to assess and to meet needs and interests of each individual resident through purposeful activity. Responsibility: A qualified Activities Coordinator is responsible for the planning, implementation and supervision of the activities program.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		10/9/15

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F 309	Continued From page 18 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper foot support was provided in the wheelchair for 1 of 2 residents (R10) reviewed for positioning. Findings include: R10's current diagnoses according to her physicians progress note dated 7/8/15, included dementia, history of frequent falls, advanced arthritis and bilateral foot drop. R10's annual Minimum Data Set (MDS) assessment dated 7/20/15, revealed she required total assistance of two staff for transfers and did not ambulate. A Care Area Assessment (CAA) did not trigger with the MDS. R10's care plan dated 9/17/15, indicated R10 was dependent on one to two staff for transfers with a hoyer lift and dependent on staff for repositioning. The care plan also indicated staff assisted her with mobility on and off the unit in a reclining [wheel] chair. During observation on 9/14/14, at 12:39 p.m. R10 was observed seated in a reclining wheelchair in the lobby. R10's feet were hanging downward without support and did not reach the floor.	F 309	R10 had an occupation therapy evaluation for wheelchair position on 9/23/15. Recommendation made for a new wheelchair. R10 was measured for a customized wheelchair by a wheelchair specialist on 10/6/15. A new wheelchair with adequate foot support has been ordered and will arrive in 4-6 weeks. COTA located a tilt space wheelchair with adequate foot support that will be used in the interim. All nursing staff have been educated via a training memo posted in the break room and in the nurse's stations on proper wheelchair positioning. Staff instructed to inform supervisor if improper positioning is identified. DON or designee will monitor 10% of the residents for proper wheelchair position weekly for 4 weeks, semi monthly for 2 months and monthly for 3 months. The results will be reported and discussed at the QA quarterly meetings.	

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During observation on 9/15/15, at 12:36 p.m. R10 was observed in the dining room eating lunch. R10 was sliding downward in her chair and her feet were hanging without support with the toes pointing downward.

During observation on 9/15/15, at 4:46 p.m. R10 was again seated in the lobby area, with her feet hanging in a downward position.

During observation on 9/15/15, at 5:53 p.m. R10 was observed in the lobby with her feet pointing toward the floor unsupported and she had begun to slide down in her wheelchair. R10 was observed to be unable to shift her position when seated in the wheelchair.

During interview on 9/15/15, at 6:00 p.m. nursing assistant (NA)-A stated R10 used the reclining wheelchair as R10 had been leaning too far forward in a regular wheelchair.

During observation on 9/16/15, at 12:04 p.m. R10 was noted in the dining room in her wheelchair, with her feet dangling unsupported above the floor.

During observation on 9/17/15, at 7:29 a.m. R10 was seated in the lobby with her feet dangling downward toward the floor.

During observation on 9/17/15, at 9:40 a.m. R10 was observed seated in the lobby, with the back of her chair reclined at a 45 degree angle. R10's feet were hanging downward with the toes pointing toward the floor.

During interview on 9/17/15, at 9:12 a.m. the

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F 309	Continued From page 20 co-director of nursing (CDON) - B stated R10 had been leaning forward too far in a standard wheelchair and liked the current reclining wheelchair she was using. CDON-B stated that R10 did not have footrests for her wheelchair; however, when she saw her she was usually reclined. Certified Occupational Therapist (COTA)-A was present at this time and was asked about R10's foot support and stated, "I can see your concern with the feet when she is sitting like that." COTA-A stated he was not aware of OT evaluating R10's wheelchair positioning within the past several years he had been working at the facility. R10's clinical record lacked evidence of any Occupational Therapy (OT) assessments related to proper wheelchair positioning since 1/12. A policy was requested regarding wheelchair positioning, none was provided.	F 309		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		10/9/15

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F 441	Continued From page 21 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure resident care equipment was sanitized in a manner to prevent cross contamination between the clean and dirty areas within the laundry. This deficient practice had the potential to affect all 45 residents currently residing in the facility. Findings include: During observation of the laundry area on 9/16/15, at 10:16 a.m. an alcove was noted between the washing machines located on the designated "clean side" of the laundry	F 441	Although we do not believe there is the potential for cross-contamination in our wheelchair / commode washing area, we have nevertheless moved the location to a shower room. Once a wheelchair or commode is washed and the room is done being used for that purpose, the shower room will be disinfected prior to being used for a resident shower. A new policy and procedure is being developed and will be brought before the	

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F 441	Continued From page 22 department. This alcove area was noted to be lined with a plastic runner which had dark colored water on it which flowed over onto the floor. On the floor in front of the alcove area was a wet drawsheet. Laundry staff (L)-A stated they had been spraying out the tubs used to transport soiled linen and this was the source of the water noted on the floor and the drawsheet. A sprayer nozzle attached to a hose was noted to be hanging up in the alcove, which had water dripping from the end. The alcove area was directly in front of a clean linen rack which stored clean towels and bed linens. Linens were delivered from the contracted laundry to the facility in plastic packages. A rolling bin used for transporting clean personal laundry from the washing machine to the dryer located on the opposite side of the room was located next to the alcove where the soiled equipment was routinely cleaned. During observation of the laundry area on 9/16/15, at 11:14 a.m. with the housekeeping manager (HM,) a contracted employee (unidentified) was observed spraying a cleaning solution onto a visibly soiled (stool present) commode located in the alcove area between the washing machines. After the cleaning solution was sprayed into the commode, the equipment was rinsed with the use of the pressure nozzle sprayer. The HM confirmed that staff routinely use the alcove area located between the washers (clean side of the laundry) to clean commodes, laundry bins and resident wheelchairs. The HM stated they were unable to clean these items on the "dirty" side of the laundry because there wasn't a drain available for the soiled waste water to empty after the equipment was sprayed.	F 441	QA committee at it's next meeting. The housekeeping director will supervise to ensure that proper protocol is being followed. She will train the staff, and she, or her designee, will watch a washing and disinfecting once a month for the next six months and report the findings to the QA committee.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 23	F 441		

During observation of the laundry on 9/16/15, at 3:10 p.m. the co-director of nursing (CDON)-A stated she thought resident equipment was being sanitized elsewhere and stated the area currently used in the laundry was not appropriate as could potentially contaminate clean linen.

During observation and interview on 9/17/15, at 8:40 a.m. with maintenance assistant (M)-A confirmed the alcove area between the washing machines was constructed out of 1/4" treated plywood and was approximately three feet by four feet in size. The plywood was noted to be dark and discolored with a deteriorated appearance and was lifting up from the concrete slab underneath, approximately an inch and a half (1.5 inches) at the bottom. Between the wall and the back of the washers, a drain trough was present to collect the water draining from the machines and/or the soiled water from the spray hose. M-A estimated the distance between the cleaning station and the linen rack was approximately 3.5 feet. M-A stated he thought the resident equipment was sanitized first with a cleaning solution prior to the equipment transported into the alcove area located on the clean side of the laundry and sprayed with the hose. M-A stated staff had been using this alcove area in the laundry to clean soiled equipment ever since he had worked at the facility. M-A stated "I wish it were more enclosed, I don't like it." M-A was unsure whether any sanitation of the cleaning station itself was being done by any staff.

During observation of the laundry room on 9/17/15, at 8:54 a.m. the administrator indicated the cleaning station/alcove had been utilized for a long time. The plywood lining in the alcove was

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	245388	A. BUILDING ______ B. WING ______	09/17/2015

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F 441	Continued From page 24 observed to be worn and peeling. The administrator stated he thought there may be a better location for cleaning equipment but would have to check with maintenance, and stated this was "Probably something we should be addressing." The facility policy, last revised 12/86 indicated commodes are to be disinfected weekly by Jobs Plus. Jobs Plus employee is to clean the complete commode by spraying with Q-T solution and then pressure washer.	F 441		

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

F5447023

PRINTED: 10/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245388	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**09/15/2015**

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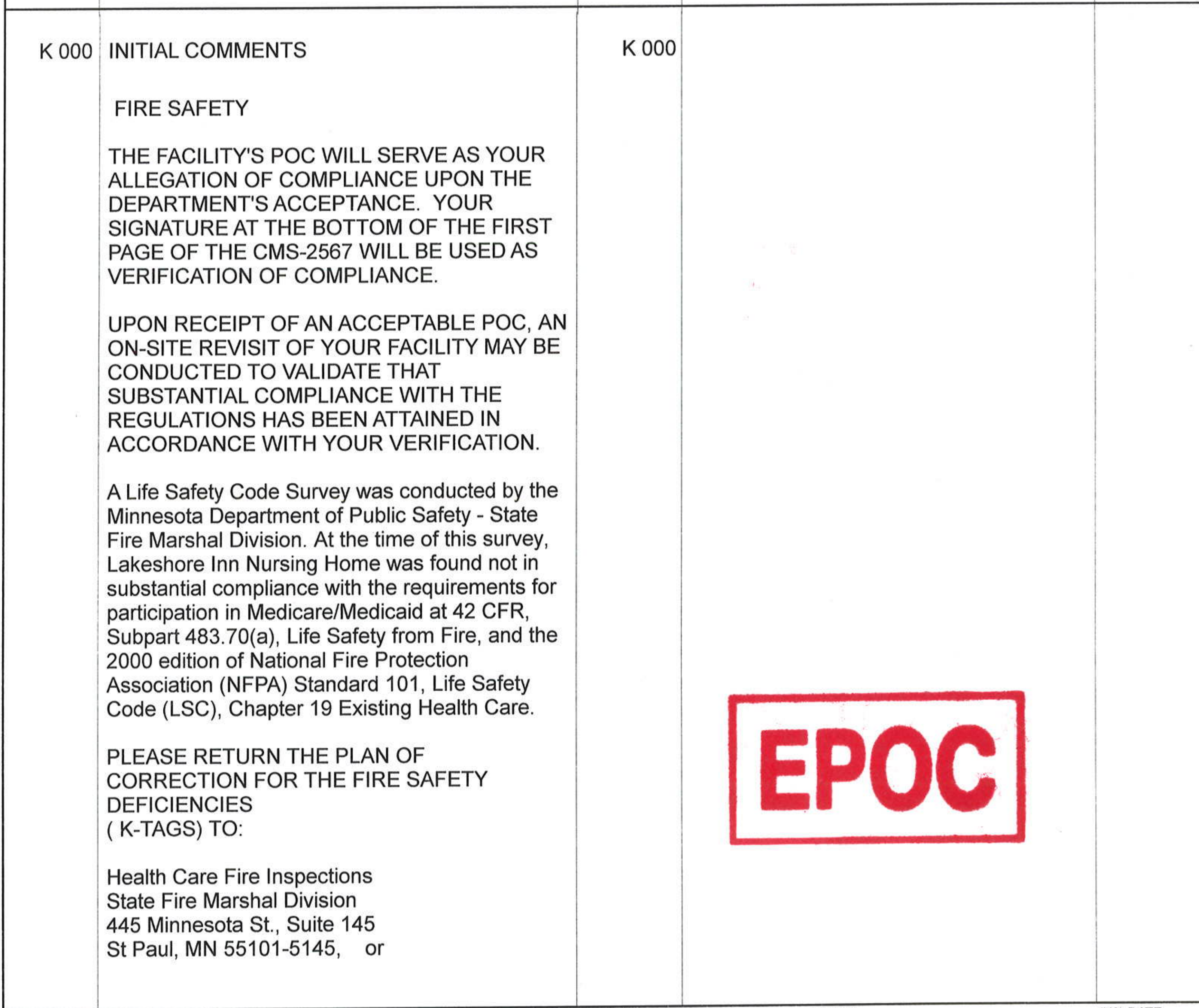
LAKESHORE INN NURSING HOME	**108 8TH STREET NORTHWEST** **WASECA, MN 56093**



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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/12/2015

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

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K 000	Continued From page 2 The facility has a capacity of 55 beds and had a census of 45 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 19.2.1 and 7.2.1.5.4, and the 2007 MN State Fire Code, Appendix I. The deficient practice could affect all 45 residents. Findings include: On facility tour between 1:00 PM and 3:30 PM on 09/15/2015, observation revealed: Locks on the Hallway Resident Rooms on East Wing have the capability of being locked by residents and the staff have no immediate way to unlock/open resident hallway doors. There is no manual unlocking device for residents rooms that all staff have access to.	K 038	All door locks have been deactivated. All of the door closures remain intact but the locking mechanisms have been removed. Maintenance director will review completion and report findings at our next QA meeting.	9/28/15

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K 038	Continued From page 3 These deficient practices were confirmed by the facility Maintenance Director (TB) at the time of discovery.	K 038		
K 154 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 1:00 PM and 3:30 PM on 09/15/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. These deficient practices were confirmed by the facility Maintenance Director (TB) at the time of discovery.	K 154	We had a combined policy that included both sprinkler and fire alarm outages combined. We now have two separate policies that meet the requirements as to having a designated person who's sole responsibility is to monitor for potential fires when the sprinkler system is not functioning. These policies will be brought up with the Quality Assurance committee for their review and approval at our next QA meeting. The administrator is responsible for creating the policy and implementation of said policy.	9/25/15

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K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 1:00 PM and 3:30 PM on 09/15/2015, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director (TB) at the time of discovery.	K 155	We had a combined policy that included both sprinkler and fire alarm outages combined. We now have two separate policies that meet the requirements as to having a designated person who's sole responsibility is to monitor for potential fires when the sprinkler system is not functioning. These policies will be brought up with the Quality Assurance committee for their review and approval at our next QA meeting. The administrator is responsible for creating the policy and implementation of said policy.	9/25/15