Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 5, 2023

Administrator
Lakeside Generations
439 William Avenue East
Dassel, MN 55325

RE: CCN: 245533
Cycle Start Date: January 12, 2023

Dear Administrator:

On March 1, 2023, the Minnesota Department(s) 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.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 5, 2023

Administrator
Lakeside Generations
439 William Avenue East
Dassel, MN 55325

Re: Reinspection Results
Event ID: V8R712

Dear Administrator:

On March 1, 2023 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 January 12, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 1, 2023

Administrator
Lakeside Generations
439 William Avenue East
Dassel, MN 55325

RE: CCN: 245533
Cycle Start Date: January 12, 2023

Dear Administrator:

On January 12, 2023, 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, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by April 12, 2023 (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 July 12, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the

dates specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

Sarah Lane

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
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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 01/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESIDE GENERATIONS	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 1/10/23 thru 1/12/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 1/10/23 thru 1/12/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. In addition to the recertification survey, the following complaints were reviewed The following complaints were reviewed with no deficiency issued. H55337315C (MN83438) and H55337259C (MN85608) The following complaints were reviewed H55337260C (MN89400) with a deficiency issued at F609. 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	F 000		

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

Electronically Signed | 02/02/2023

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 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 609		2/27/23

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F 609	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure all alleged violations of abuse were reported to the state agency (SA) for 1 of 2 residents (R8) who were reviewed for alleged abuse. Findings include: R8's annual Minimum Data Set (MDS) dated 11/25/22, identified cognitively intact with diagnoses including Post-traumatic Stress Disorder (PTSD), major depressive disorder, adjustment disorder with mixed anxiety and depressed mood, and a history of cerebral infarction. R8's care plan dated 10/11/21, listed cognitive loss/dementia with a BIMS (brief interview for mental status) score indicating cognitively intact, having poor judgement and safety awareness, lacking insight into his needs and deficits with a history of previous financial exploitation by family. When interviewed on 1/12/23, at 10:54 a.m. R8's psychologist stated she had completed a Saint Louis University Mental Status (SLUMS) test with R8 in December of 2022 in which he had scored 23/30 indicating mild cognitive impairment. R8's Psychologist stated he had deficits in his short-term memory, executive brain function and decision making. R8's progress notes dated 12/10/22, indicated resident was overheard by staff on his personal computer talking with a female from California through Facebook messenger. Staff reported this to the charge LPN. R8 reported to charge LPN	F 609	F609 Corrective Action: Facility staff will be re-educated on the policy of reporting vulnerable adult allegations in a timely manner at an all staff meeting on February 14. Vulnerable Adult report was filed and investigation was complete to ensure safety for R8. Responsible Person: Administrator Date: 2-14-23 Identification of Other Residents: Administrator will audit vulnerable adult allegations in IDT meetings to identify any allegations of unknown origin that were not reported to the state in a timely manner. Any identified cases would then be immediately identified and reported to the state by filing a vulnerable adult report. Measures Put in Place: Vulnerable Adult reporting will be presented at each staff morning meeting. The policy on vulnerable adult reporting will be included in monthly nursing meetings. Monitoring Mechanism: Audits will be completed at morning meetings to determine that all vulnerable adult cases are being reported in a timely manner. Administrator will complete these audits daily for three months and share the findings with staff at our monthly Quality Assurance meetings. Responsible Person: Administrator	

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F 609	Continued From page 3 that he was going to marry the female and he had given her the number of a $100.00 gift card he had asked his brother to get for him to buy Christmas gifts. Staff attempted to educate resident on his vulnerability and the potential for fraud. The charge LPN notified the facility social worker by phone. The charge LPN called R8's brother who is also his financial power of attorney to inform him as well. When interviewed on 1/10/23, at 4:31 p.m. the Social Services Director (SW) stated this incident was brought to her attention on Saturday 12/10/22 shortly after the occurrence and it wasn't reported to a state agency at that time as there was no confirmation that the female the resident had been communicating with had used the gift card. SW stated the gift card was purchased by R8's brother per resident request to purchase Christmas gifts for family. SW stated that she was made aware on Sunday morning 12/11/22, that the $100.00 gift card had been used and the decision was made to inform Meeker County law enforcement. SW stated she was informed by law enforcement they had filed a MAARC report and did not think another report needed to be made by the facility. When interviewed on 1/11/23, at 2:02 p.m. the administrator stated that they had not reported the incident because law enforcement had reported it and acknowledged after review of their facility vulnerable adult policy, a report by the facility should have been made within the time frames indicated by their policy. When interviewed on 1/12/23, at 8:45 a.m. nursing assistant (NA)-A stated with any suspected abuse facility protocol was to	F 609	Date: 2-27-23	

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F 609	Continued From page 4 immediately notify the charge nurse, the director of nursing, the social worker or the administrator. When interviewed on 1/12/23, at 8:55 a.m. licensed practical nurse (LPN)-A stated the protocol for suspected abuse was to immediately report suspected abuse to the on-call registered nurse, administrator, director of nursing or the social worker. When interviewed on 1/12/23, at 9:00 a.m. registered nurse (RN)-A stated that in this incident law enforcement had been called and per facility abuse policy a vulnerable adult report should have been filed by the facility. The facility policy Vulnerable Adult-MN dated 10/14/22, identified "Each employee is responsible to report without fear of reprisal immediately, any knowledge of suspected/alleged abuse, neglect, exploitation of residents" including misappropriation of resident property and to "Report all suspected/alleged violations immediately, or no later than 24 hours if the events that cause the allegation do not involve abuse or do not result in serious bodily injury to the state agency and to all other agencies as required." The facility policy Vulnerable Adult-MN dated 10/14/22, identified "Skilled Nursing Facilities (SNF's) report to MAARC instead of OHFC in very limited instances where the perpetrator is not employed by, or connected to the facility. An example of this would be financial exploitation where the perpetrator is a family member, significant other, or other non-facility and non-contracted staff."	F 609		

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F 812	Continued From page 5	F 812		
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 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 check the temperature of hot holding foods prior to serving to residents, provide for proper storage for opened food items, ensure foods were not expired, and ensure proper personal protective equipment was worn by kitchen staff. This had the potential to affect 44 of 46 residents. Further, the facility failed to have a system in place to monitor and record refrigerator/freezer temperatures for resident personal food items. This had the potential to affect 2 of 2 residents. Findings include:	F 812	F812 Corrective Action: Temperature log has been updated to ensure that staff are completing and monitoring the temperature of foods before serving to residents. All opened food items have been properly stored, marked, and discarded when necessary. All expired food items have been removed from the kitchen and discarded. Beard Guards have been ordered and employee is to where the proper personal protective equipment while in the kitchen. Refrigerator/Freezer audit logs have been updated and utilized to monitor	2/27/23

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F 812	Continued From page 6 During an observation and interview on 01/10/23, at 4:47 p.m. dietary aide (DA)-A failed to check the temperature of the food prior to serving it from the steam table. DA-A confirmed food had been in the steam table since 4:10 p.m. DA-A stated she forgot to check the temperature of the food and did not routinely document food temperatures. DA-A stated food should be at least 180 degrees. During interview on 1/10/23, at 4:50 p.m. certified dietary manager (CDM) and dietary manager confirmed temperature monitoring and logging was not a part of their practice. During observation and interview on 01/11/23, at 9:51 a.m. the dry storage unit contained; eight cans of sliced pickled beets with a best by date of 12/28/22, an opened bag of potato chips lacked opended on date, a bag of cool ranch Doritos lacked opened on date and had expiration date of 8/2022. There were 2 bags of cool ranch Doritos chips with expiration dates of 9/2022 and 10/2022, an opened package of Krusteaz pancake mix lacked an opened on date, an opened package of Stove Top stuffing lacked an opened on dated. Dietary manager stated open items were taped to sealed and discarded within one week after opened on date. During observation and interview on 1/11/23, at 10:25 a.m. cook-A was observed to have a beard without a beard net. He stated he did not think it was necessary. During an interview on 1/11/23, at 10:55 a.m. CDM stated her expectation was the cook to wear a beard net.	F 812	temperature and safety of resident personal food items. Responsible Person: Dietary Manager Date: 1/16/23 Identification of Other Residents: The temperature of hot holding foods, proper storage of food for opened food items, ensuring foods are not expired, ensuring proper personal protective equipment, and recording refrigerator/freezer temperatures has the potential to affect all residents. All items identified in corrective action have been completed by 1/16/23 to ensure the safety of all residents. Measures Put in Place: Temperature Log has been updated to add steam table temperature recording daily. Dietary Manager will complete an opened food items audit to determine that all opened foods are properly stored. Dietary Manager will complete an expired food items audit to determine that all expired foods are properly discarded. Beard guards have been ordered and dietary manager will ensure supply is on hand at all times. Refrigerator/Freezer audit logs have been updated and placed on all refrigerators. Monitoring Mechanism: Temperature Log will be audited routinely to ensure the safe temperature of foods before serving to residents. Routine audits will be completed to determine that all opened food items are properly stored. Routine auditing will be completed to determine	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 7 During observation and interview on 01/11/23, at 9:30 a.m. dietary manager stated residents were able to keep food in the coffee shop. The resident refrigerator contained unlabeled and expired pineapple. Further, the freezer contained properly labeled food. However, the thermometer showed 24 degrees which was outside the safe range. A cabinet contained an unlabeled smuckers chololate topping with expiration date of 9/16/18 and lacked an opened on date. Dietary manager stated monitoring and logging of temperatures were not a part of their practice. Further, there was no process to review for expired foods in the coffee shop. Facility policy indicated foods were to be prepared and served in a manner that complies with safe food handling practices. Opened foods were to be label with resident name and opened on date prior to being put in storage and beard restraints must be worn.	F 812	that all expired foods are discarded timely. The use of beard guards will be routinely audited to ensure compliance. Refrigerator/Freezer audit logs will be updated daily and routinely audited. Administrator will meet with Dietary Manager weekly for three months to ensure that each audit is being completed and to discuss findings of each audit. The following audits will also be presented at our monthly Quality Assurance meetings with the IDT team to ensure sustained compliance. Responsible Person: Dietary Manager Date: 2-27-23	

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	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/11/2023**

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

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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 01/11/2023. 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 | 02/02/2023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/11/2023**

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

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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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	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/11/2023**

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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 46 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25	K 353		2/27/23

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	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/11/2023**

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K 353	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to inspect and 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 5.1.1.2, and 5.2.1.1.2 This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 01/11/2023 between 09:45 AM and 12:45 PM, it was revealed by a review of available documentation that the facility was unable to provide documentation showing that a quarterly inspection was performed on the fire sprinkler system during the second and third second quarters of 2022. 2. On 01/11/2023 between 09:45 AM and 12:45 PM, it was revealed by observation, 4 sprinkler heads were showing signs of corrosion in the kitchen. An interview with the Environmental Services Director verified these deficient findings at the time of discovery.	K 353	K353 Corrective Action: The most recent fire sprinkler quarterly inspection has been conducted. The following quarterly inspection has been scheduled. Sprinkler heads covered in a foreign substance or impacted by oxidation have been scheduled to be replaced/observed by a vendor. Responsible Person: Director of Maintenance Date: 2-13-23 Identification of Other Residents: Non-compliance with sprinkler system maintenance and testing has the potential to affect all residents; this was addressed by scheduling and completing all fire sprinkler inspections, and scheduling to replace all sprinkler heads covered in a foreign substance or impacted by oxygen. Measures Put in Place: The quarterly sprinkler inspections will be placed on a calendar in the maintenance office to ensure compliance with the inspections. There will be an annual audit completed to assure that all sprinkler heads retain cleanliness. Monitoring Mechanism: Annual audits will be reviewed by the maintenance staff to ensure compliance with sprinkler head cleanliness. Maintenance will also audit to ensure that	

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	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/11/2023**

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K 353	Continued From page 4	K 353	the quarterly inspections are completed timely. Responsible Person: Director of Maintenance Date: 2-27-23	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 1, 2023

Administrator
Lakeside Generations
439 William Avenue East
Dassel, MN 55325

Re: State Nursing Home Licensing Orders
Event ID: V8R711

Dear Administrator:

The above facility was surveyed on January 10, 2023 through January 12, 2023 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.

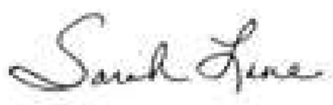
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: judy.loecken@state.mn.us
Office: (320) 223-7300 Mobile: (320) 241-7797

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.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@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 01/12/2023

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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 1/10/23 thru 1/12/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found 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	2 000		

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2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed during the survey, with no deficiency issued: H55337259C (MN85608) H55337315C (MN83438) H55337260C (MN89400) 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	2 000		

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2 000	Continued From page 2 Minnesota Department of Health. 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. SUGGESTED METHOD OF CORRECTION: TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 000		
21100	MN Rule 4658.0650 Subp. 5 Food Supplies; Storage of Perishable food Subp. 5. Storage of perishable food. All perishable food must be stored off the floor on washable, corrosion-resistant shelving under sanitary conditions, and at temperatures which will protect against spoilage. This MN Requirement is not met as evidenced by: SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee could ensure foods are stored and labeled properly to prevent potential degraded food served to residents of the facility. The facility could update or create policies and procedures, and educate staff on specific requirements or interventions related to food storage and labeling. The administrator, registered dietician, or designee could perform audits for a designated amount of time as determined by the Quality Assurance Performance Improvement (QAPI)	21100	Completed.	2/7/23

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21100	Continued From page 3 committee to ensure food items are stored and labeled appropriately. The facility could report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21100		