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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Y344

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00594

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245215**
2.STATE VENDOR OR MEDICAID NO.
(L2) **001043000**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/23/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Cheryl Johnson, HFE NE II 08/06/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 12/26/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1977
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 1/6/14 ML Y344

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/30/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5215

A standard Opportunity to Correct survey was completed at this facility on April 15, 2013. Deficiencies were found, the most serious at a Scope and Severity level of F.

On June 4, 2013, a Post Certification Revisit was conducted and one health deficiency was found uncorrected at a S/S of E. As a result, we imposed state monitoring effective June 16, 2013.

We recommended the following remedy to CMS and CMS concurred:

- Mandatory Denial of Payment for New Admissions effective July 15, 2013

A second health PCR was completed on July 23, 2013 and the facility was found in substantial compliance, effective July 23, 2013. As a result, we discontinued state monitoring effective July 23, 2013. We also recommended the following action to CMS and CMS concurred:

- Mandatory Denial of Payment for New Admissions effective July 15, 2013 be discontinued effective July 23, 2013.

Since DOPNA did go into effect, the facility is prohibited from conducting NATCEP for two years from July 25, 2013.

See the CMS-2567B for the July 23, 2013 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN# 24-5215 December 26, 2013

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

Dear Mr. Korzendorfer:

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

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

Effective July 23, 2013 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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

August 6, 2013

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

RE: Project Number S5215024

Dear Mr. Korzendorfer:

On June 11, 2013, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective June 16, 2013. (42 CFR 488.422)

We also informed you that we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 15, 2013. (42 CFR 488.417 (b))

We also informed you in our letter dated June 11, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 15, 2013.

This was based on the deficiencies cited by this Department for a standard survey completed on April 15, 2013, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on June 4, 2013. The most serious deficiency at the time of the revisit was found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On July 23, 2013, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 4, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 8, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 4, 2013, as of July 23, 2013. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 23, 2013.

In addition, this Department is recommending to the CMS Region V Office the following actions related to the imposed remedies:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 15, 2013 be discontinued effective July 23, 2013. (42 CFR 488.417 (b))

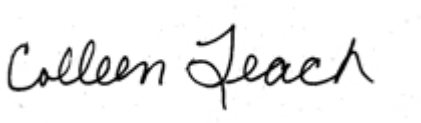
As we notified you in our letter of June 11, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 15, 2013.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,



Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245215	A. Building B. Wing	7/23/2013

Name of Facility	Street Address, City, State, Zip Code
LAKESHORE INC	4002 LONDON ROAD DULUTH, MN 55804

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0441** Reg. # **483.65** LSC	**07/23/2013**	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	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PH/cbl	08/05/2013	25479	07/23/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/15/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Y344

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00594

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245215**
2.STATE VENDOR OR MEDICAID NO.
(L2) **001043000**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY: June 4, 2013 (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
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
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathie Kiloran, HFE NEII 08/06/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 08/06/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1977
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 8/8/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/30/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5215

A Standard Opportunity to Correct survey was completed at this facility on April 15, 2013. Deficiencies were found, the most serious at a Scope and Severity level of F.

On June 4, 2013, a Post Certification Revisit was conducted and one deficiency was found uncorrected at a S/S of E. As a result, we imposed state monitoring effective June 16, 2013.

We also recommended the following remedy to CMS:

- Mandatory Denial of Payment for New Admissions effective July 15, 2013

Post Certification Revisit to follow. Please refer to the CMS 2567B.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0000 4830 8021

June 11, 2013

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

RE: Project Number S5215024

Dear Mr. Korzendorfer:

On April 18, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 15, 2013. 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 June 4, 2013, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 15, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 24, 2013. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on April 15, 2013. The deficiency not corrected is as follows:

F0441 -- S/S: E -- 483.65 -- Infection Control, Prevent Spread, Linens

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective June 16, 2013. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for

new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective July 15, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 15, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 15, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Lakeshore Inc is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 15, 2013. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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:

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802

Telephone: (218) 302-6151

Fax: (218) 723-2359

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 remedy be imposed:

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

Failure to submit an acceptable PoC 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 PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 October 15, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245215	A. Building B. Wing	6/4/2013

Name of Facility	Street Address, City, State, Zip Code
LAKESHORE INC	4002 LONDON ROAD DULUTH, MN 55804

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/24/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **05/24/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **05/24/2013**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/24/2013**	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	PH/NCS	6/11/13	29625	6/4/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/15/2013

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

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 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (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. Census 50	F 000	RECEIVED JUN 21 2013 MN Dept of Health Duluth OK 6-25-13 PCN	
{F 441} SS=E	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 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program	{F 441}	F 441 Corrective Action Resident R7 has discharged from the facility. R478, R341, R477, and R476 have had their assessments and care plans reviewed and revised as necessary. Signage related to Infection Control measures has been posted on the resident doors of R478, R341 and R477. The Director of Nursing has re-educated staff, patients and visitors on Infection Control measures, including standard, contact, droplet precautions and the C-Difficile Protocol. Employees LPN-B, RN-D, LPN-A and RN-C (who is an LPN) counseled and re-educated to policy and procedure from Clinical Nursing Skills Nursing Process Model Basic to Advanced Skills for Monitoring Blood Glucose, Handy Hygiene, Hand Antisepsis, and Gloving: CDC Recommendations and Ecumen's policy on Glucometer Cleaning. They	07-08-13

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

John Kayser Exec. Dir. 6-19-13

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 441}	Continued From page 1 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 provide appropriate infection control procedures (hand washing; use of personal protection equipment (PPE) for residents in isolation; residents for 5 of 5 residents (R27, R478, R341, R477, R476) observed during cares. Findings include: R27 was not provided appropriate infection control procedures related to handwashing and use of PPE. R27 was admitted on 5/24/13, with diagnoses that included clostridium difficile (c-diff) infection. A stool culture report dated 6/1/13, was positive	{F 441}	have been competency tested on the use of the Glucometer as well as the proper transport method and the proper cleaning technique of the Glucometer. They have also been competency tested on Infection Control Practices related to Dressing Changes. All Licensed nurses will be re-educated and competency tested on infection control practices related to PICC line flushes. All Licensed nurses will also be competency tested on Glucometer use and cleaning as well as Infection Control practices related to Dressing Changes. All Licensed nurses will be educated on cleaning of scissors between dirty and clean procedures, as well as cleaning scissors should they accidentally fall on the floor. Employee NA-A counseled and re-educated to policy and procedure on C. Difficile as well as basic infection control measures and hand washing. Identification An audit of all residents with infections will be conducted to assure that proper isolation precautions and policies on hand hygiene, proper gloving and gowning, dressing changes, scissor cleaning and flushing of PICC lines are implemented. Measures All staff will be re-educated on the C. Difficule Infection Protocol which follows Ecumen's C. Difficile policy, re-educated as to policy and procedure from Clinical Nursing Skills Nursing Process Model Basic to Advanced Skills for Hand Hygiene, Hand Antisepsis, and Gloving: CDC Recommendations. The nurses will also receive education on the proper cleaning technique for scissors between clean and dirty procedures and how to clean them if the scissors fall on the floor. Any diabetic patient who has Isolation Precautions will have a Glucometer left in their room for the duration of their infection. The Licensed nurses will be educated on the policies and will be competency tested related to PICC line flushes, Glucometer testing and cleaning (including those Glucometers left in the patient rooms) and Infection Control during dressing changes.	

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{F 441}	Continued From page 2 for c-diff. The physicians's orders dated 6/1/13, included Vancomycin (antibiotic) 125 milligrams (mg) every six hours for 10 days and Florastor (probiotic) 250 mg two times a day for 17 days for a diagnosis of c-diff. On 6/4/13, at 7:30 a.m., nursing assistant (NA)-A was observed to leave R27's room without washing hands. There was an infection control isolation cart and a sign posted outside the bedroom door directing visitors to please stop at the nurse's station. The elimination needs care plan dated 5/24/13, indicated R27 was incontinent of bowel and bladder, used an incontinence brief and required peri care after each incontinent episode. R27 required the physical assistance of one staff with transfers and toileting. The care plan was updated to indicate R27 was started on an antibiotic for c-diff on 6/1/13 due to a positive stool culture and directed patients, all staff and visitors to wash hands with soap and water prior to leaving the room. On 6/4/13, at 7:30 a.m. NA-A was observed in R27's room wearing a yellow isolation gown and gloves. At 7:33 a.m., NA-A pushed R27 in the wheelchair into the door way of the bedroom, still wearing the gloves and gown. NA-A removed the gown and gloves, but did not wash hands prior to pushing R27 to the dining room. NA-A returned to R27's room, put on gloves, picked up a hearing aid from the bedside table and attempted to put a battery into it. NA-A removed the left hand glove and succeeded with replacing the hearing aid battery. NA- A carried the hearing aid in the right gloved hand to R27 in the dining room before removing the glove and washing hands in the dining room.	{F 441}	Monitoring Daily audits x4 weeks, then weekly audits x4, then monthly audits x3, will be completed to assure that proper isolation protocols for C. Difficile, hand hygiene, and cleaning of Glucometers, PICC line flushes and Infection Control protocols for dressing changes are implemented. Audit findings will be shared with the QA Committee which meets 11 times per year. Responsible Person This will be monitored by the Nurse Managers and the Director of Nursing.	

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{F 441}	Continued From page 3 NA-A was interviewed at 8:45 a.m., and stated R27 had c-diff. NA-A stated that the nurse tells the NAs why residents are on infection control isolation or she would ask. NA-A stated she would wash her hands before leaving an isolation room, unless her hands were full. NA-A stated she attended a mandatory survey inservice and, "It was interesting, lots of good material." The NA indicated she had been audited once regarding isolation procedures. The facility undated c-diff protocol directed staff to use gloves and gowns when entering the resident's room and to be diligent about hand washing with soap, water and friction for both themselves and the infected resident. Alcohol gel is not effective against the c-diff spore. R478 was not provided appropriate handwashing during observation on 6/4/13. R478 was admitted to the facility on 5/20/13, with diagnoses that included diabetes, hypertension and stage two chronic kidney disease. A urine specimen report dated 5/31/13, was positive for staphylococcus lugdunensis and enterococcus faeciuym. The physicians orders dated 5/31/13 included Nitrofurantoin (antibiotic) 100 mg twice a day for 10 days for a diagnosis of urinary tract infection (UTI). On 6/4/13, at 8:40 a.m. NA-A was observed to exit R478's bedroom without hand hygiene. There was an infection control isolation cart and a sign directing visitors to please stop at the nurses station posted outside of R478's door.	{F 441}		

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{F 441}	Continued From page 4 The elimination care plan dated 5/20/13, indicated R478 was continent of bowel and incontinent of urine at times. R478 required assistance of one staff for incontinence care, transfers and toilet use. The infections care plan dated 5/31/13, indicated R478 had VRE (Vancomycin resistant enterococcus) in his urine and to utilize contact precautions. On 6/4/13, at 8:40 a.m. NA-A was observed to put on a yellow isolation gown and gloves before entering R478's room. At 8:43 a.m. NA-A removed the gown and gloves and exited R478's room with a small bag of trash. The NA did not wash or sanitize her hands prior to leaving the room. NA-A was interviewed at 8:45 a.m., and stated R478 had MRSA (methacillin resistant staphylococcus aureus) in his urine. NA-A stated she washed her hands with soap and water in the utility room after she dropped off the trash. NA-A stated she would wash her hands before leaving an isolation room but if her hands were full she would exit and wash later. R341 was not provided appropriate infection control for hand washing and disinfection of the scissors between dirty and clean tasks during a dressing change observed on 6/3/13, at 1:20 p.m.. R341 was admitted on 5/28/13, with diagnoses that included tibia fracture and an osteomyelitis staphylococcus infection. Physician's orders dated 5/28/13 included wound care with a dressing change to the tibia every Monday,	{F 441}		

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{F 441}	Continued From page 5 Wednesday and Saturday with Xeroform (a medicated sterile non adhering dressing used for wounds with leakage) cover with gauze and wrap with Kerlix (a wrap type dressing) and an ACE wrap. The physician orders directed staff to glove and gown for wound care due to a diagnosis of MSSA (Methacillin sensitive staphylococcus aureus) in the wound. The mobility care plan dated 5/28/13, indicated R341 had a left tibia infection, was non weight bearing and wore an immobilizer on the left lower extremity at all times. On 6/3/13, at 1:20 p.m., LPN-A cleaned the tray table and washed her hands before removing and setting up supplies from a basin kept in R341's room. LPN-A put on gloves, opened the immobilizer, removed the ACE wrap and placed a towel under R341's leg. LPN-A then reached into a pocket on the leg of her pants and pulled out a pair of scissors and cut the tape on the Kerlix dressing. The Kerlix dressing, then the gauze and Xeroform dressing were removed from the leg wounds. R341 had an open area approximately 10 centimeters (cm) round and three or four incisions with sutures. LPN-A removed her gloves, washed her hands with soap and water and applied new gloves. LPN-A cleansed the wounds with wound cleanser and gauze, applied one Xeroform dressing to the open area, cut the other Xeroform dressing in half lengthwise and applied one strip over two of the incisions. LPN-A then cut the remaining strip in half and applied to another incision. The scissors was not cleaned between cutting the soiled dressing and the clean Xeroform dressing. The Xeroform gauze was	{F 441}		

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{F 441}	Continued From page 6 covered with dry gauze and the leg wrapped with Kerlix. LPN-A then removed her gloves, washed her hands with soap and water and put on new gloves before wrapping the leg with the ACE wrap, applying the immobilizer and a non skid sock to the left foot. LPN-A cleaned up the area, removed the gloves and gown, washed hands with soap and water. LPN-A applied new gloves before tying up the garbage bag and putting a new bag in the waste basket. LPN-A removed her gloves and wiped her hands with a Sani-wipe, picked up the garbage and left the room. LPN-A returned to the room with cleaning cloth from the medication cart and sanitized the scissors, the wound cleanser bottle and the tray table. LPN-A used the hand sanitizer on the wall and left the room. LPN-A stated the isolation cart was only used when going into the room to do the dressing change and only at that time staff needed to put on a gown and gloves. The director of nursing (DON), interviewed on 6/4/13, at 11:14 a.m., stated the scissors should have been cleansed after the LPN took them from her pocket and/or before cutting the Xeroform. The DON stated that staff needed to wash hands in the bathroom of any isolation room before leaving the room. "It is what they were inserviced on." R477: Contact isolation procedures were not followed regarding use of a shared glucose monitoring machine and flushing the peripherally inserted central catheter (PICC) line. R477 diagnoses included sternal wound infection with MRSE (Methacillin resistant staphylococcus	{F 441}		

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{F 441}	Continued From page 7 epidermis), diabetes mellitus type II, hypertension, coronary artery disease, coronary artery bypass graft, diabetic peripheral neuropathy, and status post left fifth toe amputation with skin graft. The physician's orders dated 5/20/13, included contact precautions due to the MRSE infection; Vancomycin (antibiotic) intravenously (IV) twice daily by way of a PICC line; and flush the PICC line with 10 cc sodium chloride solution before and after IV medication administration; and Accuchecks [blood glucose monitoring] three times daily and at bedtime. R477's care plan dated 5/21/13, indicated a problem area of sternal wound infection of MRSE with infection control practices of contact precautions. During observation on 6/3/13, at 10:53 a.m., R477's room door was closed with a posted sign stating visitors needed to stop at the nurses' station and a three drawer isolation cart was in the hallway outside the door. On 6/3/13, at 11:23 a.m., LPN-B put on disposable gloves and entered R477's room with the facility shared blood glucose monitor and supplies to check R477's blood sugar. LPN-B stated that contact precautions for blood glucose monitoring required only gloves to be worn. LPN-B set the blood glucose monitor on R477's over bed table, inserted a blood glucose monitor strip into the machine, opened an alcohol wipe package, wiped a fingertip on R477's left hand, poked the finger with a lancet, and applied the blood to the strip in the machine. LPN-B applied	{F 441}		

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{F 441}	Continued From page 8 a small gauze to R477's finger, removed the blood glucose strip from the monitor, and carried the monitor, the strip and the lancet into the bathroom. LPN-B placed the monitor into the left hand pocket of her uniform top and placed the strip and lancet in a wall-mounted sharps container in the bathroom. LPN-B removed the gloves, applied hand sanitizer from the wall-mounted unit near the doorway, and exited the room. LPN-B removed the blood glucose monitor from her uniform top pocket and placed it on the top of the medication cart parked in the hallway outside of R477's room. LPN-B opened the bottom drawer of the medication cart, removed a wet wipe from a purple topped container, wiped down the monitor, and left the monitor wrapped in the wet wipe on top of the medication cart. On 6/4/13, at 10:25 a.m. the DON stated the blood glucose monitor should not be placed in a nurse's pocket at any time. On 6/4/13, at 7:41 a.m. registered nurse (RN)-D was observed to prepare supplies and medications at the medication cart outside of R477's room. RN-D washed her hands with soap and water at the sink in the kitchenette near R477's room. RN-D stated R477 is on contact precautions meaning a gown and gloves need to be put on before entering the room. At 7:47 a.m. RN-D put on disposable yellow gown and disposable gloves and entered the room with facility shared blood glucose monitor and supplies; oral medications in a paper cup; and a syringe filled with clear fluid. RN-D set the supplies, including the blood glucose monitor, on R477's over bed table and informed R477 what	{F 441}		

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{F 441}	Continued From page 9	{F 441}		

procedure would be completed first. RN-D completed the blood glucose monitoring procedure, leaving the machine on R477's over-bed table while she disposed of the monitor strip and lancet in the bathroom wall mounted sharps container. With the same gloves on, RN-D picked up the fluid filled syringe, walked around the bed, removed the intravenous (IV) container from the PICC line on the right side of R477's body, inserted the syringe into the line and flushed the line with the clear solution. Still wearing the same gloves, RN-D picked up another syringe, asked R477 where to give the insulin, pulled up R477's shirt to expose the abdomen, swabbed off the skin with an alcohol wipe, and injected the insulin. With the same gloves on, RN-D applied the blood pressure cuff to R477's arm and checked the BP. RN-D removed the gown and gloves and washed her hands in bathroom. RN-D picked up the blood glucose monitor with a new glove and walked out of the room. At 7:53 a.m. RN-D stated the gloves should have been changed and hands should have been washed between the blood glucose check procedure and the PICC line flush.

On 6/4/13, at 8:25 a.m. the DON stated gloves should have been changed and hands washed between the procedures of checking blood glucose and PICC line flush for R477.

On 6/4/13, at 1:45 p.m. R477 was interviewed and stated the facility had provided information on the MRSE infection and what constitutes contact precautions. R477 verbalized a high comfort level with telling the nurses or others providing care if they were not washing their hands or using gloves during or between procedures.

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{F 441}	Continued From page 10 R476: Infection control procedures were not appropriate for hand hygiene, glove use and disinfection of the scissors on 6/4/13. R476's diagnoses included lumbar discectomy and cerebral spinal fluid leak repair, gout, hypertension, atrial fibrillation, osteoarthritis, and benign prostatic hypertrophy. Physician orders dated 6/3/13, directed dressing changes to coccyx every 3 days with Aquacel ag [specific type of ulcer dressing] to wound bed and cover with Mepilex [another specific type of ulcer dressing] border. The care plan dated 5/20/13, indicated R476 had a stage 2 pressure ulcer on the buttocks. An electronic interdisciplinary progress note (IPN) dated 5/31/13, indicated R476 had a 4 cm in length by 1 cm in width by 0.1 cm in depth open area on left inner gluteal cleft. The IPN further noted a physician's order for Mepilex dressing change every 3 days and prn [as needed]. The IPN continued to note R476 needed to be turned and repositioned every hour and an air pressure mattress replaced the original mattress. On 6/4/13, at 8:34 a.m. RN-C went into R476's room with dressing change supplies and stated she would complete elbow dressing changes. RN-C donned disposable gloves and provided care to skin tears on both of R476's elbows. RN-C removed the old dressings, cleansed the elbow areas using wet wipes from R476's bathroom, and used bandage scissors to cut the telfa dressings. RN-C applied Vaseline to the telfa dressings using a q-tip applicator. RN-C	{F 441}		

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{F 441}	Continued From page 11	{F 441}		

applied the Vaseline covered telfa dressings to the elbows and used surgi-net dressings to hold the telfa in place. RN-C removed the gloves, washed her hands, and put on new gloves as two nursing assistants entered the room. RN-C stated R476 would need to get into bed for the coccyx ulcer dressing change. NA-B and NA-C were observed to transfer R476 from the wheelchair to the bed and pulled down R476's pants. RN-C positioned R476 on the left side in the bed and used adhesive remover wipes along the edges of the Mepilex dressing. RN-C removed the old dressing, rolled it up and threw it in a nearby garbage can. RN-C walked into R476's bathroom, took some disposable wipes into her gloved hands, wet the wipes with water, and returned to R476 on the bed. RN-C cleansed the ulcer on R476's bottom with the wipes and commented the ulcer looked improved since yesterday. RN-C dried the ulcer area with a bath towel, disposed of the wipes in the garbage can, and without removing the soiled gloves, opened the Aquacel dressing package. RN-C dropped the bandage scissors on the floor of R476's room, set down the dressing packages, went into the bathroom to wash the scissors with soap and water and dry them with a paper towel. RN-C returned to the bedside, took the Aquacel dressing out of the opened package, and cut a small piece of the dressing with the scissors to fit inside of R476's ulcer. Still wearing the same soiled gloves, RN-C placed the small, cut piece of Aquacel dressing in the open ulcer area, set the scissors on the bed, and opened the Mepilex dressing package along with a skin protectant barrier packet. RN-C applied the protectant on the skin surrounding the ulcer and then applied the Mepilex dressing. RN-C removed soiled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245215	A. BUILDING _____ B. WING _____	R 06/04/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 441}	Continued From page 12 gloves and washed hands. RN-C donned clean gloves and provided peri-care for R476, stating R476 had a yeast infection in the peri area and noted the rash is less inflamed than previously. RN-C completed the washing and drying of R476's peri area, and with the same soiled gloves on assisted R476 to pull up clothing and reposition R476 in bed. RN-C removed gloves and washed her hands after pulling up covers over R476. At approximately 8:45 a.m. RN-C stated the gloves should have been changed along with hands washed after removing the old dressing from R476's ulcer and before applying the new dressings. On 6/4/13, at 10:25 a.m. the DON was interviewed and confirmed gloves need to be changed along with hands washed between removing an old dressing and applying a new dressing. On 6/4/13 at 11:30 a.m., the DON was interviewed regarding general infection control practice in the facility. The DON stated that residents with MRSE, MSSA or MRSA required the same isolation precautions. All staff were expected to wear gloves and an isolation gown when entering any resident room with an isolation cart. "That is what staff have been instructed to do." The DON stated hand hygiene with a Sani-wipe or alcohol based hand sanitizer upon leaving a room was sufficient except for c-diff which required hand washing with soap and water and friction. "Everyone was trained on the protocol." The DON stated that residents with infection control isolation are provided with educational materials from the CDC (Center for Disease Control), on what type of precautions are	{F 441}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE INC	4002 LONDON ROAD DULUTH, MN 55804

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{F 441}	Continued From page 13 needed and educated on hand washing. Residents were encouraged to interrupt staff when they see possible cross contamination. The Antimicrobial Resistant Microorganisms (ARMs) policy dated as reviewed and revised on 5/11, indicated the goal was to prevent and control the spread of ARMs in the facility while maintaining quality of life for the residents. The ARMs include but are not limited to MRSA and VRE. ARMs are transmitted primarily via the contaminated hands of staff. The single most effective means of reducing the potential for ARM transmission is hand antisepsis before and after contact with residents with ARMs, including after glove removal. The facility undated MRSA, MRE, VRE AND C-Diff protocol directed staff to wash hands with soap, water and friction in the patient's bathroom before leaving the room.	{F 441}		

ECUMEN®

Lakeshore

www.LakeshoreLiving.org

The Fountains
4002 London Rd.
Duluth, MN 55804
phone 218-525-1951
fax 218-625-7808

The Shores
4000 London Rd.
Duluth, MN 55804
phone 218-625-8280
fax 218-625-8256

The Crest
4004 London Rd.
Duluth, MN 55804
phone 218-625-7805
fax 218-625-7808

Lakeshore at Home
3900 London Rd.
Duluth, MN 55804
phone 218-628-7848
fax 218-625-8274

June 19, 2013

Ms. Patricia Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, MN 55802

Dear Ms. Halverson:

Enclosed is Ecumen Lakeshore's Plan of Correction for the MN Dept. of Health re-survey that was completed on June 4, 2013

Lakeshore has indicated we will be in substantial compliance by July 8, 2013.

If I can be of any further assistance, or if you have any questions, I can be reached at (218) 625-7823 or JohnKorzendorfer@Ecumen.org.

Sincerely,

John Korzendorfer
Executive Director

JK/jml

Enc.

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Y344

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00594

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245215**
2.STATE VENDOR OR MEDICAID NO.
(L2) **001043000**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/15/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:
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
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathie Killoran, HFE NE II 05/03/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 05/29/2013 (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
07/01/1977
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 5/30/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN# 24-5215

At the time of the standard survey completed April 15, 2013, the facility was not in substantial compliance and the most serious deficiencies were found 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. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 4627

April 18, 2013

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

RE: Project Number S5215024

Dear Mr. Korzendorfer:

On April 15, 2013, 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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

Informal Dispute Resolution - 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:

Pat Halverson
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802

Telephone: (218) 302-6151

Fax: (218) 723-2359

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 May 25, 2013, 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 May 25, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 July 15, 2013 (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 October 15, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Pat Halverson

Pat Halverson, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (218) 302-6151 Fax: (218) 723-2359

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245215	A. BUILDING _____ B. WING _____	04/15/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (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 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. Census 46	F 000	RECEIVED MAY 02 2013 MN Dept of Health Duluth OK PLH 5/3/13 F282 Resident #373 has been discharged from the facility. Resident #128 discharged and admitted again on 4/19/13 and again on 4/24/13 to the facility. Tissue Tolerance Assessment, Care Plan, group sheet reviewed and (T&R and heel elevation) checklist implemented. Identification: A facility audit will be conducted on all residents requiring elevation of heels, heel boots, and off-loading from sitting position per care plan to assure the interventions are being implemented. Measures: All nursing staff will be inserviced on elevation of heels, use of heel boots, off-loading from sitting position, new documentation tool (turn and reposition and hourly off-loading check sheet), following the patient's plan of care and review group sheet. Monitoring: Weekly audits x4, then monthly x3, will be completed on all residents with a plan of care for elevation of heels, heel boots, and off-loading from sitting position to assure proper interventions are being implemented. Findings will be shared with the QA Committee which meets 11 times per year. Responsible Person: This will be monitored by the Director of Nursing.	05-24-13
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 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 did not ensure repositioning and pressure relieving services were provided as directed in the care plan for 2 of 3 residents R128 and R 373 who were reviewed for pressure ulcers. R128 was not provided pillows or heel boots to relieve pressure from her heels as directed by the plan of care. The initial care plan dated 3/26/13, indicated R128 had the potential for skin breakdown related	F 282		

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

Executive Dir. 4-30-13

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
	245215	A. BUILDING _____ B. WING _____	04/15/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 1 to left ankle wound dehiscence, a pressure ulcer on the right heel and a left ankle surgical incision. The care plan directed staff to elevate the heels off the bed with pillows and heel boots. The temporary care plan for skin/risk problems updated 4/5/13, indicated R128 had a blanchable red left heel and was to have an Allevyn to protect the area. A notation of left ankle unstageable area was added on 4/11/13. The care plan directed staff to elevate the heels off the bed with pillows and heel boots. The impaired physical mobility care plan dated 3/26/13, indicated R128 had impaired physical mobility related to a left ankle fracture and wound dehiscence. R128 was not to bear weight in the left lower leg. R128 required the assistance of one staff with bed mobility and transfers. R128 was not ambulatory. The nursing assistant (NA) care guide dated 3/26/13, directed staff to elevate heels with pillows and R128 was to wear heel boots when in bed. R128 was not provided pillows or heel boots to relieve the pressure from her heels during continuous observations on 4/10/13, from 8:25 a.m. until 10:a.m. At 8:25 a.m. On 4/11/13, at 9:20 a.m. during an interview with RN-E. The RN indicated she would expect staff to remind or encourage R128 to elevate heels and wear heel boots. The RN would expect R128 to have pillows and the the heel boots available to her due to R128 being high risk for pressure ulcers. The RN verified the care plan directed	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE INC	4002 LONDON ROAD DULUTH, MN 55804

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F 282	Continued From page 2 staff to apply the heel boots and to elevate the heels on a pillow On 4/15/13, at 10:55 a.m. during an interview with the director of nursing (DON). The DON would expect staff to remind R128 to wear the heel boots and elevate her feet as directed in the care plan. The DON would expect R128 to have the pillows and heel boots available to her. R373 was not assisted to off-load (stand up and remove pressure) from a sitting position to alleviate pressure on the left buttock pressure ulcer at one-hour intervals as directed. On 4/10/13, from 8:20 a.m. to 10:18 a.m. R373 was under continuous observation, remained seated in the wheelchair, and had interaction with two RN's, two NA's, the activity coordinator, and two maintenance workers during the two hours both in R373's room and on the second floor dining room of the facility. R373 was not assisted to stand up from a seated position until R373's spouse arrived at the facility to take R373 to a doctor's appointment. The Initial Care Plan dated 4/2/13, noted R373 had Stage 3 pressure ulcers and directed R373 to be reminded to turn and reposition every 2 hours, off-load from the chair every 1 hour for 1 minute, monitor skin every shift and prn, and provide weekly skin assessment for 4 weeks. R373's	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245215	A. BUILDING _____ B. WING _____	04/15/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 3 Temporary Care Plan for Skin Risk/Problems dated 4/2/13, directed R373 to have an air mattress in the bed and and black pad in the chair. The Nursing Assistant Group Assignment Sheet dated 4/2/13, noted R373 had Stage 3 pressure ulcers to left buttocks, and directed R373 to be reminded to turn and reposition every 2 hours and to off-load from chair every 1 hour for 1 minute. On 4/10/13, at 12:30 p.m. RN-D stated R373 was to be off-loaded every 1 hour while R373 is up sitting in the wheelchair, and confirmed she did not assist R373 with off-loading while in the room giving R373 the eye drops. On 4/15/13, at 12:15 p.m. the director of nursing (DON) was interviewed and verified R373 should have been off-loaded every 1 hour from a sitting position for pressure ulcer care to R373's left buttock area.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314	F314 Corrective Action: Resident #373 has been discharged from the facility. Resident #128 discharged and admitted again on 4/19/13 and again on 4/24/13 to the facility. Tissue Tolerance Assessment, Care Plan, Group sheet reviewed and (T&R and heel elevation) checklist implemented.	05-24-13

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F 314	Continued From page 4 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not ensure repositioning and pressure relieving services were provided as directed in the care plan for 2 of 3 residents (R128, R373) who were reviewed for pressure ulcers. R128 was not provided pillows or heel boots to relieve pressure from her heels on the morning of 4/10/13. R128's diagnoses included a history of deep vein thrombosis (blood clot), chronic obstructive pulmonary disease and a left ankle wound dehiscence (split open). The 14 day Minimum Data Set (MDS) dated 3/17/13 indicated R128 was cognitively intact and had no refusal of cares. R128 had no pressure ulcers but was was at risk for pressure ulcers. The Resident Admission, Readmission Information dated 3/26/13, indicated R128 had a 0.4 centimeter (cm) by 0.7 cm ulcer with slough and tan drainage to the right heel, as well as dry eschar that measured 0.6 cm by 0.8 cm without drainage to the right foot third toe.	F 314	Identification: A facility audit will be conducted on all residents requiring elevation of heels, heel boots, and off-loading from sitting position per care plan to assure the interventions are being implemented. Measures: All nursing staff will be inserviced on elevation of heels, use of heel boots, off-loading from sitting position, new documentation tool (turn and reposition and hourly off-loading check sheet), following the patient's plan of care and review group sheets. Monitoring: Weekly audits x4, then monthly x3, will be completed on all residents with a plan of care for elevation of heels, heel boots, and off-loading from sitting position to assure proper interventions are being implemented. Audit findings will be shared with the QA Committee which meets 11 times per year. Responsible Person: This will be monitored by the Director of Nursing.	

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F 314	Continued From page 5 The Comprehensive Skin Assessment dated 3/26/13, indicated R128 was at risk for skin breakdown due a left ankle fracture, wound dehiscence, a pressure ulcer, no weight bearing on the left leg, a Braden score of 17 (a scale used for predicting pressure sore risk, a score of 18 and below required immediate implementation of pressure relieving devices) and bladder incontinence. R128 had a wound VAC (fitted dressing with with negative pressure via wound VAC machine) on the left ankle and a pressure ulcer on the right heel. The heels were to elevated with pillows and a request for heel boots was faxed (facsimile) to the doctor. The initial care plan dated 3/26/13, indicated R128 had the potential for skin breakdown related to left ankle wound dehiscence, a pressure ulcer on the right heel and a left ankle surgical incision. The care plan directed staff to elevate the heels off the bed with pillows and heel boots. The temporary care plan for skin/risk problems updated 4/5/13, indicated R128 had a blanchable red left heel and was to have an Allevyn to protect the area. A notation of left ankle unstageable area was added on 4/11/13. The care plan directed staff to elevate the heels off the bed with pillows and heel boots. The impaired physical mobility care plan dated 3/26/13, indicated R128 had impaired physical mobility related to a left ankle fracture and wound dehiscence. R128 was not to bear weight in the left lower leg. R128 required the assistance of one staff with bed mobility and transfers. R128 was not ambulatory. The nursing assistant (NA) care guide dated 3/26/13, directed to elevate heels with pillows and	F 314		

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F 314	Continued From page 6 R128 was to wear heel boots when in bed. Interdisciplinary Progress Notes dated 3/26/13, indicated R128 was was admitted from the hospital due to the incision and drainage of the left ankle and the removal of hardware. R128 had a surgical wound on the left ankle that was covered with a wound VAC. R128 had an abrasion on the right toe with dry eschar and no drainage, as well as a stage two pressure ulcer on the right heel with a wound bed of slough and tan drainage. The surrounding skin was intact and normal. Heel boots were to be applied in bed. The Skin Ulcer Collection and Assessment (a form completed weekly to monitor ulcers) dated 3/26/13, indicated the right heel had a stage two pressure ulcer that measured 0.4 cm by 0.7 cm with a medium amount of tan/opaque drainage and red surrounding edges. On 3/29/13, the area remained a stage two pressure ulcer with no measurements recorded. The wound had epithelialized (covered) had red edges and was blanchable. On 4/5/13,the wound was a stage one and measured 0.4 cm by 0.7 cm and the edges of the wound were red and blanchable. On 3/29/13, the Skin Ulcer Collection and Assessment indicated the left ankle had a stage one pressure area that measured 1 cm by 3 cm. The area was pink in color and was blanchable. On 4/5/13 the area was described as a stage one pressure area that measured 1.7 cm by 3 cm and was a suspected to be a deep tissue injury that measured 2 cm by 1 cm with a purple center.	F 314		

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F 314	Continued From page 7	F 314		

R128 was continuously observed on 4/10/13, from 8:25 a.m. until 10:00 a.m. to not have heel boots or pillows to relieve heel pressure. At 8:25 a.m. R128 was observed sitting up on the side of the bed eating breakfast. R128 had a gripper sock on the right foot and a splint covered by an ace wrap to her knee on the left foot with the wound VAC tubing. R128 indicated she received a treatment to both heels every day and went to therapy around 10:00 a.m. The bedroom door was open and R128 was visible from the hallway. At 8:32 a.m. R128 laid herself down on the bed, on her back, with both heels directly on the mattress. At 8:38 a.m. NA-A walked by the room but did not offer heel boots or pillows to elevate the heels. At 8:41 a.m. another staff member walked by the room and did not offer the heel boots or to elevate heels on a pillow. At 8:54 a.m. NA-A again walked by R128's room without offering heel elevation. At 9:00 a.m. NA-A removed the breakfast tray from R128's room and turned the light off without offering heel boots or pillows. At 9:10 a.m. registered nurse (RN)-C, entered the room and left two inhalers, a cup with pills in it and a cup of white liquid on the tray table for R128; however, did not offer heel elevation. At 9:13 a.m. R128 sat up on the edge of the bed and took the medications. At 9:18 a.m. R128 moved pillow to the foot of the bed and put her head on it with both feet on the floor. At 9:21 a.m. RN-D entered the room to do a treatment to R128's right foot. R128's right heel had a black scab on the outer aspect that was approximately 1 cm round. The right heel was pink and blanchable. The RN indicated R128's wound VAC would be changed between 2:00 and 3:00 p.m.

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F 314	Continued From page 8	F 314		

that day and the treatment to the left heel would be done then. There were no heel boots or pillows in place and RN-D did not provide them before leaving the room at 9:28 a.m. At 10:00 a.m. the occupational therapist (OT) transferred R128 into the wheelchair, placed both feet on foot pedals and elevated them approximately 30 degrees for transport to therapy.

On 4/10/13, at 1:22 p.m. the left heel treatment was observed with RN-D. An L-shaped white splint with a salmon colored heel cup insert was removed. The wound VAC covered the outer ankle. The RN indicated the heel does not touch the heel cup at all. The RN indicated she was the first one to remove the splint and ace wrap after R128 returned from the hospital and found the area behind the left ankle above the heel at that time. RN-D stated the wound was intact, mushy and not blanchable on the medial side but blanchable on lateral side. The wound measured 3 cm by 1 cm with red edges with purple and tan areas within. RN-D stated R128's heels should be elevated on a pillow or have heel boots when in bed. "The heel boots are put on at night and removed in the morning. Whoever transferred R128 into bed should have put the heel boots on, and/or elevated the feet on a pillow so the heel are not touching the mattress.

On 4/10/13, at 1:45 p.m. (NA)-A, indicated R128 likes to sleep on her side and moves back and forth and her ankle rests on the bed. "R128's feet were on a pillow this morning."

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F 314	Continued From page 9 On 4/10/13, at 2:00 p.m. RN-D retrieved the heel boots from the top of the closet and applied them to R128's feet. RN-D verified R128 did not have any other pillows in her room. NA-A went and got 2 pillows for R128's bed. R128 indicated sometimes the NAs put the boots on but she can put them on and take them off herself. "I have restless legs and sometimes I take them off and put them on the floor between the bed and the wall." R128 indicated she did not have them on the previous night and did not have any pillows to use for her feet. RN-E, interviewed on 4/11/13, at 9:20 a.m. stated staff were to remind or encourage R128 to elevate heels and wear heel boots. RN-D said R128 should have pillows and heel boots available to her due to the high risk for pressure ulcers. RN-D verified the care plan directed use of heel boots and to elevate the heels on a pillow. The director of nurses (DON, interviewed on 4/15/13, at 10:55 a.m., stated staff were to remind R128 to wear the heel boots and elevate her feet as directed in the care plan, and R128 should have the pillows and heel boots available to her. The facility's Skin Assessment and Care policy revised on 5/11. The policy's purpose was to prevent skin breakdown and provide early intervention and treatment for existing skin problems. Expected outcomes included the prevention of the development of additional pressure ulcers or other skin problems.	F 314		

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F 314	Continued From page 10 R373 was not assisted to off-load (stand up and remove pressure) from a sitting position to alleviate pressure on the left buttock pressure ulcer at one-hour intervals on 4/10/13, from 8:20 a.m. to 10:18 a.m.. R373's diagnoses included avascular necrosis, urinary stress incontinence, hypertension, urinary tract infection, anemia, and right total hip arthroplasty. The Skin Assessment dated 4/2/13, indicated R373 was at risk for skin breakdown and had one Stage 3 pressure ulcer on the left buttock, measuring 4.0 cm in length by 2.0 cm in width with questionable undermining and had minimal serosanguineous drainage, had 20% of granulation tissue, the surrounding skin was reddened, and the skin area was suspected to contain deep tissue involvement. The Skin Ulcer Data Collection and Assessment dated 4/5/13, indicated R373's pressure ulcer on the left buttock continued to be staged at a Stage 3 pressure ulcer and measured 4.0 cm in length by 2.0 cm in width. The skin ulcer assessment dated 4/5/13, also noted R373's left buttock ulcer had no drainage, contained 10% epithelialized tissue and 20% granulation tissue, no undermining or tunneling, and the surrounding skin was reddened.	F 314		

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F 314	Continued From page 11 R373's faxed New Admission Physician Orders dated 4/2/13, directed Duoderm dressing changes to Stage 3 pressure ulcer every 3 days and prn [as needed]. The Initial Care Plan dated 4/2/13, noted R373 had Stage 3 pressure ulcers and directed R373 to be reminded to turn and reposition every 2 hours, off-load from the chair every 1 hour for 1 minute, monitor skin every shift and prn, and provide weekly skin assessment for 4 weeks. R373's Temporary Care Plan for Skin Risk/Problems dated 4/2/13, directed R373 to have an air mattress in the bed and and black pad in the chair. R373's electronic Treatment Administration Record (ETAR) dated 4/1/13, to 4/30/13, indicated the Duoderm dressing to Stage 3 pressure ulcer on buttocks was changed on 4/7/13. Review of R373's medical record revealed no further documentation of R373's pressure ulcer or skin condition. The electronic Interdisciplinary Progress Notes (IPN) dated 4/2/13, indicated R373 was alert and oriented x 3 [aware of person, place, and time], was able to call for assistance, and had a short-term memory loss. The IPN further noted R373 had a Stage 3 pressure ulcer to the left buttocks, and had orders to remind R373 to turn and reposition every 2 hours and to off load from chair every 1 hour for 1 minute. The IPN continued to note R373 needed extensive assistance of 1 person for transfers and	F 314		

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F 314	Continued From page 12 ambulation on and off the unit. The Nursing Assistant Group Assignment Sheet dated 4/2/13, noted R373 had Stage 3 pressure ulcers to left buttocks, and directed R373 to be reminded to turn and reposition every 2 hours and to off-load from chair every 1 hour for 1 minute. On 4/8/13, at 1:06 p.m. registered nurse (RN)-D was interviewed and stated R373 was admitted with a Stage 3 pressure ulcer on the left gluteal area which was being treated with a Duoderm dressing which was to be checked daily and changed every 3 days. On 4/10/13, during continuous observation from 8:20 a.m. to 10:18 a.m., R373 remained seated in the wheelchair. During that time there were interactions with two RN's, two NA's, the activity coordinator, and two maintenance workers, both in R373's room and in the second floor dining room. R373 was not assisted to stand up from a seated position until the spouse arrived to transport R373 to a doctor's appointment. On 4/10/13, at 10:25 a.m. NA-B stated R373 was to be off-loaded every 1 hour for 1 minute as R373 had a pressure ulcer on her left buttock area. NA-B confirmed she did not do that for R373 this morning.	F 314		

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F 314	Continued From page 13 On 4/10/13, at 12:30 p.m. RN-D was observed to care to R373's left buttock pressure ulcer. RN-D put on gloves and proceeded to remove Duoderm dressing from R373's left buttock area. RN-D then washed R373's buttock area with warm, wet wash cloth and measured ulcer area, stated ulcer is a Stage 2 measuring 0.3 cm in length by 0.7 cm in width with the rest of the discolored skin covering both buttock cheeks as a Stage 1 pressure ulcer and measuring 10 cm in length by 7 cm in width. RN-D continued to describe the area as 100% epithelialized with no drainage, no odor, or no pain and with blanchable and discolored skin and possible deep tissue across buttocks. RN-D then removed gloves, did not wash hands, and donned new gloves. RN-D removed old dressing from right hip incision from total hip arthroplasty surgery and noted the staples were intact and skin was pink. RN-D cleansed incision with an alcohol wipe, and applied a new, dry dressing, covering the incision. RN-D held the incisional dressing in place while RN-C taped the dressing down to R373's skin. RN-C then stated the Duoderm was not the appropriate dressing for R373's pressure ulcer treatment, and applied an Allevyn dressing instead. RN-C assisted R373 pull up [his/her] lower extremity clothing, removed the gloves, and washed her hands. On 4/10/13, at 12:30 p.m. RN-D stated R373 was to be off-loaded every 1 hour while up sitting in the wheelchair, and confirmed she did not assist R373 with off-loading while in the room giving R373 the eye drops. On 4/15/13, at 12:05 p.m. RN-E was interviewed	F 314		

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F 314	Continued From page 14 and stated R373 should have been off-loaded every one hour per the care plan for left buttock pressure ulcer. On 4/15/13, at 12:15 p.m. the director of nursing (DON) was interviewed and verified R373 should have been off-loaded every 1 hour from a sitting position for pressure ulcer care to R373's left buttock area.	F 314	F371 All staff will be required to attend a mandatory inservice to review the "Equipment and General Cleaning Policy" and "Labeling and Dating of Food Policy" which have been revised to incorporate items related to this survey by May 24, 2013. A newly created cleaning schedule, which assigns tasks to each staff position daily, will be implemented by May 24, 2013. Continued monitoring of these policies and the cleaning schedule will occur on a daily basis by the Dietary Manager, Executive Chef, or the Registered Dietitian. Any staff out of compliance by not completing the assigned tasks will be subject to the appropriate step in the disciplinary process. Responsible Person: Dietary Manager	05-24-13
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure food was prepared and stored in a clean environment. This had the potential to affect 45 of 46 residents who resided in the facility. Findings include: On 4/8/13, at 6:10 a.m. an initial tour of the kitchen was conducted with cook- A present. The following was observed during the tour: In the walk in refrigerator had trays of cubed pineapple, cantaloupe and muskmelon which had not been	F 371		

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F 371	Continued From page 15	F 371		

dated. In the same refrigerator were several slices of dry appearing cheese which were wrapped in saran wrap and not dated. There were two undated large pans of meatloaf that were covered with tin foil except for the ends of the tinfoil which had been flipped back. Cook-A stated the tin foil was opened at the ends for cooling purposes. Cook-A also stated the meatloaf had been prepared 4/7/13 and was to be served 4/9/13. A small mixer was noted to be covered with a black plastic bag. The black plastic bag was removed and Cook-A verified the mixer had visible signs of a white flour like substance and several splatters of brown crusted substance around the guard where the mixing bowl sits and on the outside of the mixer. Cook-A stated the mixer had not been cleaned as it should have been although the black plastic bag indicated it was clean. Next to the small mixer sat a large floor mixer. The large uncovered mixer had several white and brown crusted substance covering the inside and outside of the mixer. There was a large mixing bowl placed in the mixer with white flakes of an unidentified substance in it. Cook-A stated the mixer had not been used today (4/8/13) she removed the mixing bowl and stated the bowl should not had been placed on the mixer until it was ready for use. Cook-A also verified the uncleanliness of the large mixer and stated the mixer should have been cleaned last night and ready for the day shift staff to use. A knife block mounted on the wall had visible dust covering the entire top of the block where the knives slid into. A four shelf stainless steel cabinet with stored pots and pans had visible greasy substance with dust stuck to it on all four shelves. A second four shelf stainless steel cabinet with stored mixing bowls and the

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LAKESHORE INC	4002 LONDON ROAD DULUTH, MN 55804

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F 371	Continued From page 16 inserts for the steam tables also had visible greasy substance with dust stuck to it on all four shelves. The outside of the stainless steel cabinets had dried food splatters on the sides and fronts. Two stainless steel prep tables had dried yellow/green substance on the top of the table and on the lower shelf. Cook-A verified the substance as pea soup from the previous night. Cook-A also stated the prep tables should have been cleaned after use last night [4/7/13.] Kitchen refrigerator #2 had nine cups of mixed fruit and ten cups of cole slaw that were dried out in appearance and not covered or dated as verified by Cook-A. An undated, large bag of thawed chicken breasts in a shallow pan was observed on the bottom rack of the refrigerator with an empty bag with chicken drippings was placed on top of the bagged chicken. In small refrigerator #3 there were three ice cream toppings (2 caramel and 1 chocolate), two coffee creamers, and a container of cool whip, all with no open dates on them. On a rack in the kitchen there were nine large taco shells which were not covered or dated. Cook-A stated the taco shells were made yesterday [4/7/13] and should have been covered and dated. A four foot, grate covered floor drain located in the kitchen near the prep area was noted to have large amounts of food that could have prevented fluid draining in the event of fluid spillage. The director of food services (DFS), interviewed on 4/11/13, at 11:30 a.m., stated he tried to schedule extra days for staff to come in and clean the kitchen; however, that has not happened for some time due to staffing issues. DFS provided a cleaning schedule for the month of March and	F 371		

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F 371	Continued From page 17 April of 2013. The cleaning schedule had several blanks as well as staff names indicating the tasks had been completed. Some of the duties listed on the logs included monitoring food for proper storage and dates, cleaning and sanitizing all work areas and checking all equipment for cleanliness. The undated policy titled: Equipment and General Cleaning read: "All equipment will be properly cleaned and sanitized by staff following each use and inspected for proper cleanliness prior to each use. Cleaned equipment shall be protected as appropriate to maintain cleanliness... Staff shall date and initial equipment following cleaning procedures for equipment not utilized on a regular basis." The policy titled:Labeling and Dating of Food, dated as reviewed 10/10, read: "All food items whether received from truck, case opened, or prepared are to be labeled, dated, and initialed by any and all staff members handling same. All food items are to be covered, wrapped, or placed in resealable bag and properly stored. All prepped foods stored on ladder racks must be properly labeled, dated, and initialed."	F 371		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	F 431	F431 Corrective Action: Employee RN H counseled and re-inserviced to policy and procedure on Medication Storage in the Facility.	05-24-13

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F 431	Continued From page 18 controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 4 medication carts were locked when not attended by nursing personnel. Findings included:	F 431	Identification: All residents have the potential to be affected by this deficient practice. Measures: All nurses will be re-inserviced on the Medication Storage in the Facility Policy and Procedure. Monitoring: Weekly audits x4, then monthly x3, will be completed to assure that medication carts are locked when unattended per Policy and Procedure. Findings will be shared with the QA Committee which meets 11 times per year. Responsible Person This will be monitored by the Director of Nursing.	

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F 431	Continued From page 19 On 4/8/13, during the medication administration task, registered nurse (RN)-H was observed to leave the medication cart unattended and unlocked on three different medication pass observations for the second floor Fountains 2 area. On 4/8/13, at 6:56 a.m. RN-H was observed to remove medications from the medication cart and enter a resident's room, leaving the medication cart in the hallway without locking the medication cart. At 7:00 a.m. RN-H returned to the cart and continued to pass medications on the second floor hallway of Fountains 2 facility area. On 4/8/13, at 7:12 a.m. RN-H was again observed to remove medications from the medication cart, left a medication on top of the cart while entering the resident's room to ask the resident a question, and then returned to the cart and continued to prepare the medications to be given to that resident. RN-H then re-entered the resident's room, leaving the medication cart in the hallway outside the resident's room against the hallway, not locked, and not within RN-H's vision while she passed medications to a resident in the room. At approximately 7:20 a.m. RN-H returned to the cart and continued to pass medications from the cart. On 4/8/13, at 7:30 a.m. RN-H was again observed to remove medications from the medication cart in the hallway on second floor of Fountains 2 facility area. RN-H was then called	F 431		

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F 431	Continued From page 20 away to attend to another resident. RN-H placed the prepared medications in the top drawer of the medication cart and shut the drawer, left the medication cart unlocked and unattended, and walked down the hallway to another resident's room. RN-H returned to the cart at 7:32 a.m. and resumed preparing the medications for a third resident. RN-H left the medication cart in the hallway, not locked, and proceeded to administer in the resident's room 3 inhaled medications along with several prepared oral medications. RN-H returned to the medication cart at approximately 7:40 a.m. On 4/8/13, at approximately 7:40 a.m. RN-H was interviewed and stated the medication cart was not locked when it should have been on this date and should always be locked when not in attendance of nursing personnel. On 4/15/13, at 12:05 p.m. RN-E was interviewed and stated medication carts needed to be locked between med passes, when the nurse leaves the cart in the hallway and enters a resident's room. On 4/15/13, at 12:20 p.m. the director of nursing (DON) confirmed the medications carts needed to be locked when not attended. Review of the Medication Pass policy reviewed and revised 5/2011, directed the medication cart is to be locked if not in full view of a licensed nurse or TMA (trained medication assistant).	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 21 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 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	F 441	F 441 Corrective Action Residents R 6 has discharged from the facility on 4/25/13, R 97 has discharged from the facility on 4/14/13, and R 373 has discharged from the facility on 4/27/13. R 30 had discharged from the facility 4/12/13 and returned as a new admit on 4/19/13. Care plan reviewed, isolation signage posted on door, family, patient, and staff educated on standard and droplet precautions. Employee RN H counseled and re-inserviced to policy and procedure from Clinical Nursing Skills Nursing Process Model Basic to Advanced Skills for Monitoring Blood Glucose, Hand Hygiene, Hand Antisepsis, and Gloving: CDC Recommendations and Ecumen's policy on Glucometer Cleaning. Employee H-A counseled and re-inserviced to policy and procedure on C. Difficile. Employee RN D counseled and re-inservied to policy and procedure from Clinical Nursing Skills Nursing Process Model Basic to Advanced Skills for Hand Hygiene, Hand Antisepsis, and Gloving: CDC Recommendations. Employee NA A counseled and re-inserviced to policy and procedure from Clinical Nursing Skills Nursing Process Model Basic to Advanced Skills for Hand Hygiene, Hand Antisepsis, and Gloving: CDC Recommendations and to policy and procedure on C. Difficile. Employee RN I counseled and re-inserviced to policy and procedure from Clinical Nursing Skills Nursing Process Model Basic to Advanced Skills for Hand Hygiene, Hand Antisepsis, and Gloving: CDC Recommendations and to policy and procedure on C. Difficile. Identification An audit of all residents with C. difficile will be conducted to assure that proper isolation precautions and policies on hand hygiene, proper gloving and gowning, cleaning of room are implemented.	05-24-13

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F 441	Continued From page 22 by: Based on observation, interview and document review the facility failed to develop and operationalize effective infection control procedures to minimize the potential for infections and cross contamination for 2 of 2 residents (R97, R30) observed with contact isolation. In addition, gloves were not worn, hands were not washed, and the blood glucose monitor was not sanitized per infection control protocols for 1 of 1 residents (R6) who were observed for blood glucose monitoring procedures; and gloves were not changed between procedures and hands were not washed for 1 of 3 residents (R373) who were observed for pressure ulcer care. The systemic breakdown with infection control practice had the potential to impact all 46 of 46 residents in the facility. Findings include: Upon entering the facility on 4/8/13, at approximately 6:00 a.m., an infection control isolation cart was observed outside of resident R97's room. There was no sign directing visitors to check with the nurse prior to entering R97's room. The registered nurse (RN)-D stated it was "c-diff(clostridium difficile CDI) and R97 was on contact precautions. When asked what contact precautions were, RN-D stated staff are to wear gloves only if they touch something. RN-D stated R97 was on his third course of antibiotics for CDI. According to the Centers for Disease Control (CDC), Contact Precautions are defined as	F 441	Measures All staff will be inserviced on the new C. Difficile Infection Protocol which follows Ecumen's C. Difficile policy, re-inserviced to policy and procedure from Clinical Nursing Skills Nursing Process Model Basic to Advanced Skills for Hand Hygiene, Hand Antisepsis, and Gloving: CDC Recommendations. All nurses will be re-inserviced on Ecumen's policy on Glucometer Cleaning, and from Clinical Nursing Skills Nursing Process Model Basic to Advanced Skills for Monitoring Blood Glucose. Monitoring Weekly audits x 4 then monthly x3 will be completed to assure that proper isolation protocols for C. Difficile, hand hygiene, and cleaning of glucometers are implemented. Audit findings will be shared with the QA Committee which meets 11 times per year. Responsible Person This will be monitored by the Nurse Managers and the Director of Nursing.	

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F 441	Continued From page 23 "Healthcare personnel caring for patients on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the patient room is done to contain pathogens, especially those that have been implicated in transmission through environmental contamination." R97 had recurrent CDI without consistent implementation of infection control interventions. R97 had multiple diagnoses including C-Diff. The 30 day Minimum Data Set (MDS) dated 3/22/13, indicated R97 had no cognitive impairment, was continent of bowel/bladder, and required staff assistance for transfers, mobility, toileting and personal hygiene. R97 was admitted to the facility on 2/22/13, with a physicians order for Vancomycin 125 milligrams (mg) four times a day for 14 days for a diagnosis of intestinal infections due to CDI. The end date for the Vancomycin was 2/28/13, as R97 had received some of the antibiotic prior to admission. A nurse progress note dated 3/7/13, indicated R97 had 3 loose stools during the night, a low grade temperature of 99.1, and R97 had complained of feeling fatigued and wiped out. R97 had 3 more large loose stools that morning with 2 stools being incontinent. The progress note also indicated a stool specimen had been collected for CDI and was sent to the lab and the	F 441		

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F 441	Continued From page 24 Vancomycin had been completed on 2/28/13. Another nurse's progress note dated 3/7/13, indicated the stool specimen was positive for CDI and the results had been faxed to the physician. The physician's order dated 3/8/13, directed staff to administer Vancomycin 125 mg twice a day for 14 days for diagnosis of CDI. A nurse progress note dated 3/10/13, indicated R97 continued to have loose stools and was his "third fight" with CDI. There was no further documentation regarding R97's bouts of loose stool until 3/24/13, a nurse progress note indicated R97 had reported his stools had returned to normal, however, R97 was to continue on Vancomycin. A nurse progress note dated 3/29/13, indicated R97 continued on Vancomycin for CDI, with stools resolved with formed bowel movements. At some point (undocumented) contact precautions were initiated. R97 had reported to staff that his stools had returned to normal on 3/24/13; however, continued on the Vancomycin (stop date 4/19/13) . The bowel and bladder detail report identified R97's last loose stool was 3/23/13, formed stools were documented daily up to 4/10/13. According to the infection control nurse on 4/15/13, at 11:00 a.m. facility practice was to observe for 3 formed stools prior to the resident being considered free of the CDI. Although R97 had formed stools for 18 days, R97 remained on contact precautions. There was no system in place to remove residents from contact precaution once the symptoms of CDI were resolved. On 4/9/13, at 12:13 p.m. R97 was observed to	F 441		

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F 441	Continued From page 25 have an isolation cart outside of his room and a newly posted sign below R97's room number directing visitors to check at the nurses station prior to entering the room. The sign was not there the previous day. An interview on 4/9/13, at 12:19 p.m. with RN-G stated, R97 was on contact precautions due to diagnosis of CDI. RN-G described contact precaution as not needing to wear gloves or a gown unless staff comes into direct contact with R97 or something in his room. RN-G also stated she had posted the "new" sign to direct visitors to the nurse prior to entering the room as it was a new policy they had just created. RN-G also stated staff were responsible to encourage visitors to wash their hands prior to entering and leaving R97's room. 4/9/13, at 1:40 p.m. R97 had a male and female visitor who were observed sitting in his room with no gloves or gowns on. The visitors were interviewed at 1:55 p.m. as they were leaving R97's room. Both visitors stated they had not seen the sign posted to see the nurse prior to entering the room nor did the resident or staff inform them of any contact precautions they should be aware of. R97 came out of his room during the conversation and asked what was going on? R97 stated in a loud voice "what the hell is that sign there for?" (pointing at the see nurse sign prior to entering room). R97 was asked if anyone had explained to him what the sign was about and he replied, "no!" and "No one has said anything to me and I'm going home Saturday no matter what that sign means." RN-E was interviewed on 4/9/13, at 1:59 p.m. and stated R97 was currently being treated for CDI and the sign was just placed on the wall today.	F 441		

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F 441	Continued From page 26 RN-E also stated contact precautions are in effect and she would expect staff to glove and gown when caring for R97. RN-E also stated she would expect visitors to know R97 was on precautions and expect them to wear gloves and wash their hands prior to leaving the room. RN-E stated she had not spoken to R97 regarding the precautions and CDI but was planning to. R97's bowel and bladder assessment dated 2/22/13, identified R97 had CDI and was continent of bowel and bladder. The RN analysis indicated R97 currently had diarrhea related to CDI. The interventions were to prevent constipation by increasing fiber, fluids, and ambulation. The goal was for R97 to have formed bowel movements and prevent urinary tract infections. R97's infection care plan dated 2/22/13, identified R97 had CDI with loose stools and staff were to use contact and standard precautions. It was not identified as to what the precautions consisted of and when to use them. R30 was being tested for CDI without consistent implementation of infection control interventions. R30 diagnosis included muscle weakness, pneumonia, and contact precautions until CDI is ruled out. The 14 day MDS dated 4/1/13, indicated R30 had no cognitive impairment and needed extensive assist with toileting needs and personal hygiene.	F 441		

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F 441	Continued From page 27 On 4/9/13, at 1:40 p.m. R30 was observed to have an isolation cart outside of his room with a sign posted on the wall below his room number which directed visitors to see the nurse prior to entering the room. RN-G was interviewed on 4/9/13, at 1:50 p.m. and stated R30 had diarrhea and a stool specimen was sent in today [4/9/13] to rule out CDI. RN-G also sated R30 is on contact precautions until the results of the stool specimen come back. On 4/10/13, at 9:06 a.m. nursing assistant (NA)-A entered R30's room to change the bed linens without donning gloves or a gown. NA-A removed the pad from the top sheet, placed it in a linen bag in the room, and without washing hands, went out of the room to the linen closet and retrieved a clean pad. NA-A continued making R30's bed. Without washing hands, NA-A was observed to enter another residents room where the surveyor intervened to asked her to wash her hands. NA-A was interviewed on 4/10/13, at 9:13 a.m. and stated R30 was suspected of having CDI but it hasn't been confirmed yet. NA-A was questioned regarding contact precautions and she stated she would only use gloves if she visibly saw soiled linen otherwise she would not wear the gloves or the gown. On 4/10/13, at 9:36 a.m. RN-I was observed to put on gloves, but no gown, from the bin outside of R30's door and then entered the room. RN-I assisted R30 with changing his pants as he was incontinent of urine. NA-A entered the room with	F 441		

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F 441	Continued From page 28 a plastic bag and no gloves on and RN-I placed R30's soiled laundry into the bag. NA-A brought the bag to the utility room and did not wash her hands after disposing of the soiled linen bag. R30's son arrived at 9:40 a.m. and introduced himself to surveyor. Son had not noticed the sign placed on the wall to see the nurse prior to entering the room and stated he had been there last night too and no one had said anything to him about R30's contact precautions. RN-I approached the son and explained to him that R30 has had diarrhea and was currently on precautions until the results are back from the stool specimen. RN-I encouraged son to wash his hands prior to leaving the room. Housekeeper (H)-A was interviewed on 4/11/13, at 10:00 a.m. H-A stated she knows when a resident has an infection because there's a plastic bin placed outside the door. H-A stated she was not sure what type of infection R30 or R97 had but she should have asked the nurse. H-A sated she cleaned the rooms daily with a quat cleaner which disinfected the surfaces such as the tray table, mattress, dresser drawers and on all surfaces. H-A also stated she used a neutral disinfectant for the bathroom floor and a disposable mop head. H-A stated she was not allowed to use bleach for cleaning. An interview on 4/11/13, at 10:15 a.m. with RN-E stated she would expect staff to wear gloves and a gown while changing bed linens regardless if the linens were visibly soiled or not. RN-E also	F 441		

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	245215	A. BUILDING _____ B. WING _____	04/15/2013

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F 441	Continued From page 29	F 441		

stated there is lack of communication between the different departments and the front line staff regarding infection control practices as well as contact precautions.

The housekeeper supervisor (HKS), interviewed on 4/11/13, at 10:52 a.m., stated staff are aware of contact precautions by seeing the bins outside the residents rooms and he would expect the housekeeping staff to check with the nurse to find out what type of infection the resident has. HKS stated the quat cleaner was not appropriate to use for CDI as it has no bleach product in it. He also stated the bathroom cleaner does not have bleach in it either and housekeeping staff should be using the Clorox wipes to disinfect the rooms. HKS stated he has not had any training with the housekeeping staff regarding CDI and appropriate cleaning products as he had just started working there 4 months ago. HKS agreed the staff needed to be educated on proper products to disinfect CDI.

The manufacturer's data sheets for neutral cleaner and the quat cleaner indicated neither product kills CDI spores.

The director of nursing (DON), interviewed on 4/15/13, at 11:05 a.m., verified the lack of contact precautions signs to alert visitors to see the nurse prior to entering the room. The DON stated she would expect all staff to use gloves prior to entering a room that has been labeled as contact precautions. The DON would expect staff to gown if staff were to touch anything in the room. She

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F 441	Continued From page 30 also stated staff should treat a suspected case of CDI the same way a confirmed case would be treated until the lab work came back to verify if indeed it was positive or not. The DON explained once a resident has formed stools for 3 days they are considered negative for CDI and could be removed from contact precautions. DON verified R97 should have been removed from contact precautions once his stools were formed for 3 days. The DON stated there was a systemic breakdown with communication from front line staff to other departments regarding what contact precautions are and when to remove residents from the precautions once they are asymptomatic. The DON stated there needed to be some education provided for all staff. The undated C-diff protocol, directed staff to use gloves when entering a resident's room to do direct care and environmental contact. Gowns should be worn if soiling likely.The protocol also directed staff to be diligent about handwashing, for both themselves and the infected resident. The C-Diff spore can be spread through oral-fecal contact which means anything unwashed hands touch can become contaminated. The protocol went on to explain the spores can live on a surface up to a month or longer. Soap, water and friction are to be used for cleansing hands. The protocol indicated bleach based cleaners/disinfectants need to be used for cleaning hard surfaces that could be contaminated. Surfaces should be wiped down after each diarrhea occurrence (this includes: bed pans, bed rails, toilet seat, handle, door knobs, grab bars, sinks and faucets) In a addition housekeeping was to do hard surface cleaning	F 441		

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F 441	Continued From page 31 once a day with 10% bleach solution. R6 was not provided adequate infection control measures during blood glucose testing. R6's current, signed physician's orders dated 3/26/13, directed daily Accuchecks [blood glucose monitoring]. On 4/8/13, at 6:56 a.m., RN-H was observed performing a blood glucose monitoring procedure for R6. RN-H removed the blood glucose monitor from a drawer in the medication cart and proceeded to clean off the outside of the machine with a wet wipe obtained from a purple-topped container from the bottom drawer of the cart. RN-H entered R6's room, with the blood glucose monitor in hand along with oral medications to be administered to R6. RN-H did not wash her hands or don gloves prior to beginning the procedure. RN-H set up the blood glucose monitor on R6's bed side table, asked R6 which finger to poke, and then wiped that finger off with an alcohol wipe, poked the finger using a disposable lancet which produced a drop of blood. RN-H then wiped the blood away with a small, dry gauze, and allowed R6's finger to bleed a small amount. RN-H proceeded to apply the blood drop from R6's finger tip to a blood glucose monitor strip which was set up in the monitor. RN-H gave R6 a gauze to hold on the finger to stop any further bleeding. RN-H read the monitor and verbalized the blood glucose reading to R6. RN-H removed the strip from the monitor, offered R6 the oral medications and some water, and left R6's room, without washing her hands. RN-H	F 441		

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F 441	Continued From page 32 returned the blood glucose monitor to the drawer in the cart without sanitizing. RN-H continued to perform the medication pass task for the other residents. On 4/8/13, at approximately 7:10 a.m. RN-H was interviewed and stated gloves should have been worn for the blood glucose monitoring procedure and hands should have been washed before and after the procedure was complete. RN-H confirmed she did not wear gloves, wash hands, or sanitize the blood glucose monitor before returning it to the medication cart drawer. RN-H verified the monitor was shared in that hallway amongst residents requiring blood glucose monitoring. On 4/15/3, at 12:05 p.m. RN-E was interviewed and stated the glucometer should have been wiped with the solution in the purple-topped container after use and before being put away in medication cart, and gloves should have been worn during the blood glucose monitoring procedure with hands washed after the procedure was completed. On 4/15/13, at 12:20 p.m. the director of nursing (DON) was interviewed and verified the hand washing, gloving, and cleaning procedures were not followed in this instance. An untitled and undated document regarding blood specimen collection indicated hand hygiene and don gloves were to be performed for monitoring of blood glucose. The document failed to include the directions and the cleaning product to be used for blood glucose monitor cleaning and maintenance.	F 441		

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F 441	Continued From page 33	F 441		

R373's pressure ulcer care and incision care were provided without appropriate infection control procedures..

R373's diagnoses included avascular necrosis, urinary stress incontinence, hypertension, urinary tract infection, anemia, and right total hip arthroplasty.

R373's faxed New Admission Physician Orders dated 4/2/13, directed Duoderm dressing changes to Stage 3 pressure ulcer every 3 days and prn [as needed].

On 4/10/13, at 12:30 p.m. RN-D was observed to care to R373's left buttock pressure ulcer. RN-D put on gloves and removed the Duoderm dressing from R373's left buttock area. RN-D then washed R373's buttock area with warm, wet wash cloth and measured ulcer area, stated ulcer is a Stage 2 measuring 0.3 cm in length by 0.7 cm in width with the rest of the discolored skin covering both buttock cheeks as a Stage 1 pressure ulcer and measuring 10 cm in length by 7 cm in width. RN-D continued to describe the area as 100% epithelialized with no drainage, no odor, or no pain and with blanchable and discolored skin and possible deep tissue across buttocks. RN-D then removed gloves, but did not wash hands before donning new gloves. RN-D removed old dressing from right hip incision from total hip arthroplasty surgery and noted the

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F 441	Continued From page 34 staples were intact and skin was pink. RN-D cleansed incision with an alcohol wipe, and applied a new, dry dressing, covering the incision. RN-D held the incisional dressing in place while RN-C taped the dressing down to R373's skin. RN-C then stated the Duoderm was not the appropriate dressing for R373's pressure ulcer treatment, and applied an Allevyn dressing instead. RN-C assisted R373 pull up [his/her] lower extremity clothing, removed the gloves, and washed her hands. On 4/10/13, at approximately 12:30 p.m. RN-D was interviewed and stated the gloves were not changed after the old dressing was removed from R373's right hip incision, wound care was completed and a new dressing was applied to R373's right hip wound. RN-D further stated the gloves should have been changed and hands washed before proceeding to a different dressing change procedure for R373. On 4/15/13, at 12:05 p.m. RN-E was interviewed and stated hands should be washed and new gloves applied between the two dressing change procedures for R373. An infection control policy for gloving and hand washing for ulcer and wound care was requested on 4/11/13, but none was provided by the facility.	F 441		

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	245215	A. BUILDING **02 - NEW REPLACEMENT BLDG** B. WING _____	**04/09/2013**

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K 000	INITIAL COMMENTS Surveyor: 03005 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Lakeshore Lutheran Home was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 200 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 18 NewHealth Care. Lakeshore Lutheran Home is a two story building with a full basement, constructed in 2004 and opened in 2005. The construction type is determined to be Type I(443). The building is fully sprinkler protected. The facility has a complete automatic sprinkler system, with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. All resident rooms have single station smoke detectors that transmit to the nurses station. The facility has a licensed capacity of 60 beds, the census was 55 at the time of inspection.	K 000		

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

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