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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZVFZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00682

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

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

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

4. TYPE OF ACTION: 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 **08/31/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **42** (L18)

13. Total Certified Beds **42** (L17)

10. THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Elizabeth Silkey, Unit Supervisor 10/05/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 10/05/2021 (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 **12/01/1986** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **08/30/2021** (L33)

DETERMINATION APPROVAL

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
October 5, 2021

CMS Certification Number (CCN): 245388

Administrator
Lakeshore Inn Nursing Home
108 8th Street Northwest
Waseca, MN 56093

Dear Administrator:

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 September 14, 2021 the above facility is certified for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically Delivered
October 5, 2021

Administrator
Lakeshore Inn Nursing Home
108 8th Street Northwest
Waseca, MN 56093

RE: CCN: 245388
Cycle Start Date: June 24, 2021

Dear Administrator:

On August 31, 2021, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: ZVFZ
Facility ID: 00682

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/24/2021** (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	
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FISCAL YEAR ENDING DATE: (L35) **12/31**

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To (b) :

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A. In Compliance With
Program Requirements
Compliance Based On:
___ 1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathy Hahn, HFE NE II 08/26/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 08/27/2021 (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)

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B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 16, 2021

Administrator
Lakeshore Inn Nursing Home
108 8th Street Northwest
Waseca, MN 56093

RE: CCN: 245388
Cycle Start Date: June 24, 2021

Dear Administrator:

On June 24, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by September 24, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by December 24, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

specified for compliance or the imposition of remedies.

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245388	A. BUILDING: ______ B. WING ______	6/24/2021

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 623

Notice Requirements Before Transfer/Discharge
CFR(s): 483.15(c)(3)-(6)(8)

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245388	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 6/24/2021
NAME OF PROVIDER OR SUPPLIER **LAKESHORE INN NURSING HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **108 8TH STREET NORTHWEST WASECA, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 623

Continued From Page 1

and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure a written transfer notice was given to 1 of 1 residents (R22) upon transfer to the hospital. In addition, the facility failed to have a system in place to ensure residents/resident representatives were given written notice upon transfer. This deficient practice had the potential to affect all 23 residents residing in the facility.

R22's quarterly Minimum Data Set (MDS) assessment dated 6/7/21, indicated R22 was cognitively intact, had adequate hearing, impaired vision, clear speech, could make self understood and was able to understand. R22 required extensive assistance from one or two staff for bed mobility, transferring, dressing, toileting and hygiene. R22 did not walk.

A progress note dated 4/6/21, at 11:32 a.m. indicated R22 was transferred by ambulance to a local hospital with stroke symptoms. Progress note dated 4/6/21, at 2:10 p.m. indicated R22 would be admitted to the hospital.

During an interview on 6/24/21, at 1:31 p.m. the director of nursing (DON) stated they do not inform the resident or resident representative in writing when a resident required transfer. The DON was not aware this was required; stating she thought they just needed to enter a note in the resident's medical record that the resident representative was informed of the transfer.

Facility did not have a policy for providing written notice of transfer.

F 625

Notice of Bed Hold Policy Before/Upon Trnsfr
CFR(s): 483.15(d)(1)(2)

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245388	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 6/24/2021
NAME OF PROVIDER OR SUPPLIER **LAKESHORE INN NURSING HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **108 8TH STREET NORTHWEST WASECA, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES

F 625

Continued From Page 2

goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-
(i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
(ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;
(iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
(iv) The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure the resident, or resident's representative was provided written information regarding bed hold policy at the time of hospitalization for 1 of 1 residents (R22) reviewed for hospitalization. This deficient practice had the potential to affect all 23 residents residing in the facility.

Findings include:

R22's quarterly Minimum Data Set (MDS) assessment dated 6/7/21, indicated R22 was cognitively intact, had adequate hearing, impaired vision, clear speech, could make self understood and was able to understand. R22 required extensive assistance from one or two staff for bed mobility, transferring, dressing, toileting and hygiene. R22 did not walk.

R22's progress notes dated 4/6/21, at 11:32 a.m. indicated R22 was transferred by ambulance to a local hospital with stroke symptoms. In addition, this progress note indicated paperwork had been prepared for the transfer including a bed hold. A progress note dated 4/6/21, at 2:10 p.m. indicated R22 would be admitted to the hospital.

During an interview on 6/24/21, at 11:00 a.m. social services (SS)-A stated as part of the admission process, the facility bed hold policy was discussed with the resident and/or resident's representative and a copy of the policy was provided to them upon admission. Further, SS-A stated when R22 was transferred to the hospital on 4/6/21, the facility bed hold policy was sent along to the hospital, but a copy of this was not retained by the facility. SS-A requested and received a copy of this document from the receiving hospital. The document was titled "Hospital and Therapeutic Leave Policy." The document did not have space for staff to sign, date/time, nor did it have space to document that the bed hold was provided to the resident/resident representative at the time of the transfer.

During an interview on 6/24/21, at 1:31 p.m. the director of nursing (DON) stated they did not use a bed hold form that is filled out, but rather they sent the bed hold policy to the facility when a resident was transferred.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245388	MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	DATE SURVEY COMPLETE: 6/24/2021
NAME OF PROVIDER OR SUPPLIER **LAKESHORE INN NURSING HOME**	STREET ADDRESS, CITY, STATE, ZIP CODE **108 8TH STREET NORTHWEST WASECA, MN**		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 625	Continued From Page 3

Continued From Page 3

The DON was not aware it was required to send notice of bed hold to the resident/resident representative at the time of transfer; stating she thought they just needed to enter a note in the resident's medical record that a bed hold was sent to the receiving hospital.

During an interview on 6/24/21, 1:50 p.m. the administrator stated he was familiar with bed holds and the business office handled them, however, the business office staff were not in the facility. The administrator stated he would speak to them upon their return and submit this document if it existed, however none was received.

Facility policy titled Hospital and Therapeutic Leave Policy, undated, indicated:
--Definitions for hospital leave and therapeutic leave; how a resident who is non-medicaid paying would be billed; now a resident receiving medical assistance benefits would be affected. Further, it indicated to prevent a discharge from the facility, the resident/representative party my pay privately to hold the bed until the resident returns, paying the full daily care-mix amount. The resident/representative party should make these arrangements with the facility prior to exceeding the allowable bed hold days.
--Residents that are transferred with expectation so return to the facility but their welfare and needs can no longer be met by the facility and is no longer able to provide needed care/services will not be allowed to return to the facility.
--This letter was notification of the facility "Bed Hold" policy as required by the Federal OBRA standards.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245388	A. BUILDING ______ B. WING ______	C 06/24/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 06/21/21 through 06/24/21, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator	E 041		8/16/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed TITLE (X6) DATE: 07/26/2021

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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E 041	Continued From page 1 must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the	E 041		

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E 041	Continued From page 2 availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009.. This REQUIREMENT is not met as evidenced by: Based on interview, the State Deputy Fire Marshal identified the facility failed to comply with the Life Safety Code of replacing the emergency power generator battery if greater than thirty	E 041	During the pandemic, our generator maintenance provider got off of their schedule. This caused the batteries to be just a few days past the limit. They will be	

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E 041	Continued From page 3 months old. This deficient practice had the potential to affect the safety of all residents, staff and visitors in the facility. Findings Include: The State Deputy Fire Marshal conducted a facility tour and inspection on 06/23/21. It was observed by the State Fire Marshall that the emergency power generator battery was not dated and so it could not be confirmed if it was less than thirty months old. The State Deputy Fire Marshall stated this will be cited as a deficient practice.	E 041	getting the battery inspection and replacement back on the regular schedule and they will be clearly marking the dates the batteries were replaced. The Maintenance Director will monitor this area to ensure continued compliance. He will perform spot audits and report findings to the Quality Assurance Committee at its quarterly meeting.	
F 000	INITIAL COMMENTS On 6/21/21 to 6/24/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5388018C (MN67924) however NO deficiencies were cited due to actions implemented by the facility prior to survey: The following complaints were found to be UNSUBSTANTIATED: H5388019C (MN70612) H5388017C (MN65486) H5388016C (MN60288) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required	F 000		

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F 000	Continued From page 4 at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and develop an intervention to accommodate needs and promote independence with the ability to perform hand hygiene and utilize the sink in the resident's shared bathroom for 1 of 1 resident (R223) reviewed for accommodation of needs. Findings include: R223's face sheet printed on 6/22/21, indicated R223 was admitted on 6/21/21, with a diagnosis of infection due to right hip prosthesis (artificial body par). R223's care plan dated 6/23/21, identified resident needed help with bathing, bathroom use, to get ready in the morning and evening due to impaired mobility, infection and reimplantation of right hip joint. Interventions	F 558	We disagree with the surveyors finding in this area. We feel it was a one-time incident that in no way rises to a deficient practice. However, in the spirit of cooperation we have taken the following steps to ensure that we provide the highest level of care to our residents. We immediately cleared out the bathroom in question and removed the oxygen concentrator making the room accessible for resident R223. All bathrooms in the building were assessed to make sure resident needs are accommodated. We have reviewed our Accommodation of Needs policy. Staff has been re-educated on the Accommodation of Needs policy (CNA's,	8/16/21

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F 558	Continued From page 5	F 558		

included time to do tasks, praise progress/effort, give rest periods during task, transfer with the help of two people bearing weight, use the bathroom with the help of one to two people to transfer on and off the toilet, change pad, do peri-care and adjust clothing, usually continent of bowel and bladder. Unable to walk, moves about the unit with the help of one person in the wheelchair, dress with the help of one person, hygiene/grooming tasks with the help of one person, wash hands and face after setup, staff assist with combing hair and with peri care, cleans own teeth and gums with set up. R223's care plan goal was to improve ability to participate in ADL' s in three months.

R223's occupational therapy plan of care dated 6/22/21, identified oral hygiene set up or clean up assistance, helper sets up or cleans up, resident completes activity, helper assists only prior to or following the activity, and discharge plans to return home when able.

R223's progress note dated 6/21/21, at 3:00 p.m. indicated R223 had no upper extremity loss of range of motion, alert and orientated, primary mode of locomotion was with a wheelchair.

On 6/22/21, at 10:40 a.m. R223 stated she was admitted to the facility yesterday, and staff told her she could not use the shared bathroom, resident indicated she did not know why she was not able to use the bathroom. The shared bathroom was observed with a entrance blocked with an oxygen concentrator and commode located in front of the bathroom sink. R223 further indicated teeth were brushed and hair combed independently.

nurses, housekeeping,and Social Service) by a training memo that covered all of the appropriate topics.

The Directors of Nursing or designee will perform weekly, facility wide monitoring to ensure resident rooms are set up to accommodate resident needs. They will continue this weekly testing for two months.

The results of audits will be reviewed by the Quality Assurance Committee at its quarterly meeting.

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F 558	Continued From page 6	F 558		

Continued From page 6

On 6/23/21, at 8:00 a.m. R223 entrance to the shared bathroom was observed and R223's bathroom doorway was blocked by an oxygen concentrator.

On 6/23/21, at 1:00 p.m. trained medical assistance (TMA)-A stated R223 did not use her bathroom, when asked why TMA-A indicated R22's room did not have space for her oxygen concentrator and commode, and therefore the items were placed in the shared bathroom. TMA-A further confirmed R223 would not be able to access the bathroom with R22's items in the bathroom.

On 6/23/21, at 1:10 p.m. RN-B indicated R223 used the bedside commode for toileting and does not have access to the bathroom due to R22's items in the bathroom.

On 6/23/21, at 2:43 p.m. interview with social services stated she assisted with R223's admission and was unaware the resident was not able to access her bathroom and further confirmed R223 should have access to the bathroom. Social services indicated she completed the admission interview and did not assess the shared bathroom at the time of admission.

On 6/24/21, at 8:08 a.m. interview with director of nursing (DON)-A and DON-B indicated residents should have access to the shared bathrooms and other resident's personal property should not be stored in the bathroom to limit a resident from entering the bathroom. R223's bathroom was observed with the DON's and acknowledged and confirmed R223 was not able to access the shared bathroom with R22's oxygen concentrator

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F 558	Continued From page 7 and commode that blocked R223's entrance and access to the sink. The DON's stated they expected all residents to have access to the shared bathroom and would expect residents to access the bathroom to wash hands and brush teeth. On 6/24/21, at 9:44 a.m. an interview with the administrator indicated he was not aware R223 did not have access to the shared bathroom and expected the resident's bathroom to be clear of other residents' belongings and the others resident's oxygen concentrator should not block the bathroom entrance. A facility policy regarding accommodations of needs was requested and not received.	F 558		
F 678 SS=D	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure there was a system for consistent code status verification for 1 of 1 residents (R18) reviewed for advance directives. Findings include: R18 was admitted to the facility on 11/16/20. Diagnoses included stroke, diabetes and chronic obstructive pulmonary disease.	F 678	We have taken the following steps to ensure continued compliance with this area. Once notified of a concern in this area, we immediately clarified the residents CPR status with the residents health care POA and their health care provider. The residents chart was immediately updated as well. We further reviewed the charts of	8/16/21

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R18's quarterly minimum data (MDS) assessment dated 5/24/21, indicated R18 had severe cognitive impairment, clear speech, could make self understood and usually understood others. R18 required extensive assistance of one staff for bed mobility, transfer, walking in her room, moving about in a wheelchair, dressing and toileting.

R18's care plan did not mention her code status (the type of emergent treatment a person would or would not receive if their heart or breathing were to stop). Code status being absent from care plan was confirmed by the director of nursing (DON)-A on 6/24/21, at 8:59 a.m.

R18's physician order in the electronic medical record (EMR) indicated do not resuscitate/do not intubate (DNR/DNI), which meant if R18 stopped breathing and/or her heart stopped breathing, she would not be resuscitated.

During record review, it was noted that R18's Physician Orders for Life-Sustaining Treatment (POLST) found in R18's paper chart, did not match the physician order in the EMR. The following discrepancies were noted:
--the physician order in the EMR indicated R18's code status was DNR/DNI.
--R18's paper chart had two POLST documents. One indicated to attempt resuscitation/CPR (cardiopulmonary resuscitation) and the other indicated do not attempt resuscitation/DNR.
--One POLST was signed by R18 and the other was signed by family member (FM)-E.
--Neither POLST was signed by a physician or provider which was required according to the document.

all residents to make sure that the charts of all residents were correct.

Do CPR green stickers were removed from the outside of resident chart. CPR cheat sheets (3" x 5" white paper notes) were removed from bulletin boards throughout facility. All current charts were reviewed to ensure code status verification.

Going forward, Code status will be verified with resident and/or representative upon admission. A telephone order will be obtained at that time from provider reflecting CPR status. A POLST form will be filled out on new admissions. A copy will be placed in colored sleeve in front of paper chart. Original will be placed in folder for provider signature. Once signed by provider, the POLST form will replace copy in colored sleeve in front of paper chart.

Should there ever be a change in a resident's CPR status, this will trigger the completion of a new POLST form which will update the status in the resident chart. This new POLST form will be signed by the resident or their health care POA and the health care provider of the resident.

Nurses will be educated via training memo on POLST forms, policy and how to determine resident CPR status.

POLST will be reviewed at quarterly care conferences.

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F 678	Continued From page 9 --One POLST was dated 11/16/20, and the other was not dated. During an interview on 6/22/21, at 2:22 p.m. trained medication aide (TMA)-A stated the code status for residents was posted at the nurses station on a slip of paper. This slip was approximately 3 inches x 5 inches that listed "Do CPR" at the top and listed five resident names below: R14, R16, R18, R22, R4. TMA-A stated she was responsible for updating the slip. The slip indicated it was last updated 3/12/21. In an emergency, TMA-A stated she would look at the residents medication administration record (MAR) in the EMR to determine code status. During an interview on 6/22/21, at 2:37 p.m. registered nurse (RN)-A stated to determine the code status of a resident in an emergency, she would look at the admission documentation in the EMR. In addition, RN-A stated the code status was listed in two other places: on a slip of paper in the nurses office and at the nurses stations; and if a resident wanted CPR, a green sticker was placed on the spine of the residents paper chart that read "do CPR." During an interview on 6/22/21, at 2:56 p.m. DON-A stated the process for determining the code status of a resident started on admission when a POLST was filled out and the provider signed it. A copy of the POLST was then placed in the residents paper chart. If a resident wanted CPR, a bright green sticker was placed on the spine of the residents paper chart. In addition, the DON-A stated there was a "cheat sheet" at the nurses station that listed the residents who wanted CPR. DON-A stated "but I wouldn't stake my license on it that it's right." DON-A stated she	F 678	Directors of nursing or designee will audit all new admissions on a weekly basis for the next two months to ensure clear code status verification. Results will be reported to the Quality Assurance Committee at its quarterly meeting.	

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would go to the paper chart and look at the POLST to determine a residents code status.

During an interview on 6/23/21, at 2:50 p.m. licensed practical nurse (LPN)-A stated to determine a residents code status in an emergency, she would look for the green sticker on the spine of the residents paper chart.

During an interview on 6/23/21, at 3:31 p.m. (RN)-B stated she would look at the POLST in the residents paper chart to determine a residents code status in an emergency.

R18's paper chart had a green sticker on the spine that indicated "DO CPR," which was in conflict with the physician order for DNR in R18's EMR.

On 6/23/21, at 3:45 p.m. the code status discrepancy for R18 was brought to the attention of DON-A. DON-A removed both POLST documents from R18's paper chart and reviewed them. DON acknowledged they were in conflict; that neither were signed by the provider and only one of them was dated. DON-A was asked if she was aware the physician order in the EMR indicated R18 was a DNR and after looking in R18's EMR, stated "you are right." DON-A stated she did not know why there were two POLST's and why they weren't signed by the provider. DON-A "I would say we would do CPR." DON-A contacted nurse practitioner (NP)-D and read both POLST's to her over the phone. After speaking to NP-D, it was decided DON-A would call family member (FM)-E to verify R18's code status. At 4:15 p.m., DON-A left a phone message for FM-E, adding she had to call him to clarify..."we can't go another 10 minutes not

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knowing." In the meantime, DON-A received a provider visit note from the local clinic which documented a conversation between NP-D and FM-E on 11/17/20, which read in part: if R18 had no pulse and was not breathing, do not attempt resuscitation. No CPR or intubation. DON-A was not able to determine how this discrepancy happened and acknowledged that it was possible in an emergency R18 could have received CPR when her wishes were DNR "and that would not have been good."

During an interview on 6/24/21, at 8:35 a.m. DON-A stated there was no policy on POLST's, nor were there policy or procedure outlining the use of the green stickers or slips of paper at the nurses station indicating residents who want CPR. DON-A stated that in an emergency, "looking at the POLST was the gold standard and we need to get rid of everything else." DON-A was informed of the various responses from nursing staff when asked where they would look for a residents code status in an emergency: green sticker, slip of paper at the desk, EMR, MAR, and POLST. DON-A admitted the various means of identifying a residents code status could result in the incorrect code status being initiated for a resident in an emergency. DON-A stated nurses needed to look at the POLST and stated changes would need to occur to ensure all nursing staff relied on the POLST for determining code status.

During an interview on 6/24/21, at 10:15 a.m. the administrator stated he was familiar with code status, and relied on the two DON's to determine processes and policy around it.

Policy titled Cardio-Pulmonary Resuscitation

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

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F 678	Continued From page 12 (CPR), dated 4/24/19, indicated: --Facility will provide basic life support, including CPR to residents requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the residents advanced directives. --CPR will be initiated unless: 1) a valid DNR order is in place; 2) obvious signs of clinical death are present 3) initiating CPR could cause injury or peril to the rescuer. --The procedure on how to do CPR was outlined.	F 678		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of	F 755		8/16/21

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receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

§483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure a system for periodic reconciliation of controlled or narcotic medications in 1 of 1 emergency kit (E-Kit). This had the potential to affect any of the 22 residents present in the facility who may require controlled medications from the E-Kit and refrigerators.

Findings include:

On 6/22/21, at 2:15 p.m. a tour of the south unit medication room was conducted with registered nurse (RN)-A. Located within the locked medication room was a locked cabinet with an E-Kit. The E-kit was observed to have two yellow secured tags present and included lorazepam (an anti-anxiety medication/controlled substance), morphine (narcotic pain medication/controlled substance), and hydrocodone (a narcotic pain medication/controlled substance). RN-A indicated if the E-Kit was opened and medications were removed, nursing staff would remove the yellow tags (which locked the E-Kit) and replace with red tags to secure the E-Kit until the pharmacy came to change out the E-Kit. The tour further indicated a locked refrigerator on the south unit to contain an E-Kit. The E-kit was observed to have a yellow secure tag present and included 2 mg lorazepam vial and RN-A confirmed the lorazepam was not being reconciled. RN-A stated the pharmacy

We have taken the following steps to ensure continued compliance in this area.

We have written and implemented a new policy on Emergency Kit reconciliation. Part of this policy utilizes an Emergency Kit reconciliation log. Licensed nurses will verify tag numbers and integrity of tags on refrigerated and non-refrigerated Emergency Kits at each shift change.

Licensed nurses will be educated on policy by training memo.

Directors of Nursing or designee will spot audit the Emergency Kit reconciliation log once a week for the first month, and then once a month for the next two months. The results will be reported to the Quality Assurance Committee at its quarterly meeting.

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F 755	Continued From page 14 came to the facility weekly. On 6/23/21, at 11:12 a.m. RN-B confirmed being aware the E-kit included lorazepam, hydrocodone, morphine, further confirmed nursing staff did not include the narcotic contents from the E-Kit with their narcotic counts. RN-B stated when medications were removed from the E-kit, the DON was notified. On 6/24/21, at 7:30 a.m. the director of nursing (DON)-A and DON-B confirmed the E-kit was not reconciled daily, the DON's stated they were not aware of the medications in the E-kit and were not aware the E-Kits were to be reconciled. On 6/25/21, at 8:15 a.m. via telephone interview the consultant pharmacist, she indicated the e-kits were expected to be inspected daily and ensured the E-kit tags were secured. The policy titled, Controlled Substances dated 12/2012, included: Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together They must document and report any discrepancies to the Director of Nursing.	F 755		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		8/16/21

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F 812	Continued From page 15 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to label opened containers of food, not sanitize a deep fat fryer in storage, and not sanitize the kitchen commercial can opener. These deficient practices had the potential to affect all 22 residents who received food from the kitchen. Findings include: During the tour of the kitchen on 6/22/21, at 9:36 a.m. with the on-duty facility cook (Cook)-A, the following food containers were found opened without an open date identified: Dry storage in the kitchen: Rice Krispies cereal, bread sticks, moldy hot dog buns, five pastries in a plastic serving box, bulk flour and sugar bins, and wild rice. Bulk dry storage in the storage room: carrot cake mix and panko crumbs stored in 6 quart buckets. The storage buckets had an opened date label of 5/1/20, however, Cook-A stated dry goods should be discarded after six months after opening.	F 812	The Dietary manager and Kitchen manager will reinforce the importance of following policy of labeling and dating foods, whereby all foods will be labeled and dated according to date procured, opened or prepared and perishable foods will be used within 7 days (with few exceptions for commercially packaged items). Dry goods will be used within 6 months This shall be completed in the form of mandatory inservice held by dietary director and licensed dietitian. The can opener cleaning has been added to the daily cleaning list. It will be run through the dishwasher on a daily basis. The countertop deep fryer has been removed from the building and is no longer in use. We have decreased the amount of product that we keep on hand to minimize the chance of having any expired food. The Dietary director and kitchen manager	

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F 812	Continued From page 16 Refrigerator: three hamburger patties, wilted lettuce, five corn dogs, Alfredo Sauce, and Italian sausage. Freezer: three strawberry salads not covered or dated. During the kitchen tour it was also discovered that an electric countertop deep fryer in the storage room was filled with frying oil and was not cleaned or drained from oil before putting in storage. Cook-A stated not knowing how long the deep fryer had been in storage. Additionally, the commercial kitchen can opener had dried food on the opener knife. During an interview on 06/22/21, at 10:06 a.m. kitchen manager (KM)-A stated the kitchen has had a lot of trouble with outdates of opened food. KM-A stated it is a constant battle with staff to label opened food because of significant staff turnover. KM-A stated open food and beverages must be labeled with the opened date or discarded if not dated. The facility Policy & Procedure Manual from Becky Dorner & Associates, copy write 2000, pages 136-138, titled Food Storage, directed to keep foods safe with proper storage, all opened foods and beverages must be clearly labeled and dated of when it is opened.	F 812	will conduct random audits to ensure compliance to policy. They will audit 1/4 of the dry storage area each week for one month, hitting the entire area in the first month. The next two months they will audit half of the storage area the first month and then the other half in the second month. The Dietary director and kitchen manager will audit the can opener for cleanliness on a weekly basis for one month, then monthly for the next two months. They will report their findings to the Quality Assurance Committee at its quarterly meeting.	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		8/16/21

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designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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F 880	Continued From page 18 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure multi-use glucometers (blood sugar monitor machines) were disinfected between resident use for 4 out of 9 diabetic residents (R1, R3, R6, R22) observed to have blood sugar checks. Findings include: On 6/23/21, at 10:52 a.m. registered nurse (RN)-B was observed to remove a glucometer from the top drawer of the south treatment medication cart and stated the facility utilized one glucometer per unit to obtain resident's blood sugars. RN-B entered R6's room with the facility's	F 880	We have taken the following steps to ensure continued compliance in this area. The glucometers in question were immediately cleaned and all nurses were re-educated as to the policy and procedure regarding the use of multi-use glucometers. We have reviewed and updated our policy on glucometer disinfecting. We will no longer be using multi-use glucometers. A glucometer will be provided for each diabetic resident and cleaned per policy.	

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F 880	Continued From page 19 communal glucometer device, a new lancet (finger stick device) and a test strip from the medication cart. RN-B donned gloves and utilized the lancet to obtain a blood drop and placed it on the glucometer strip in the machine. Once the glucometer reading registered, RN-B removed her gloves, exited the room, placed the lancet into a sharps container and placed the glucometer on the top of the medication cart. RN-B disinfected her hands and failed to disinfect the glucometer. On 6/23/21, at 10:55 a.m. RN-B was observed to wheel the medication cart to R3's room. RN-B picked up the unclean community glucometer, a lancet and a test strip and entered R3's room. RN-B donned gloves and obtained a blood sample with the lancet. RN-B placed the blood on the strip and obtained the blood sugar reading. RN-B removed her gloves, exited the room, placed the lancet into the sharps container and placed the glucometer on the medication cart. RN-B utilized hand sanitizer to wash her hands but was not observed to disinfect the glucometer. On 6/23/21, at 10:58 a.m. RN-B wheeled the medication cart to R1's room. RN-B picked up the unclean community glucometer, a lancet and a test strip and entered the doorway of R1's room. RN-B donned gloves and obtained a blood sample with the lancet. RN-B placed the blood on the strip and obtained the blood sugar reading. RN-B removed her gloves, exited the room, placed the lancet into the sharps container and placed the glucometer on the medication cart. RN-B utilized hand sanitizer to wash her hands but was not observed to disinfect the glucometer. On 6/23/21 at 11:00 a.m. RN-B was observed to	F 880	Glucometers will be kept in individual labeled zip lock bags and stored in medication or treatment carts or tote. Education will be provided to nursing staff via training memo on proper procedures and infection control standards related to sanitizing glucometers. Directors of Nursing or designee will observe blood sugar checks and disinfecting of glucometers randomly for all residents once weekly for one month. They will They will report their findings to the Quality Assurance Committee at its quarterly meeting.	

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wheel the medication cart to R22's room. RN-B picked up the unclean community glucometer, a lancet and a test strip and entered R22's room. RN-B donned gloves and obtained a blood sample with the lancet. RN-B placed the blood on the strip and obtained the blood sugar reading. RN-B removed her gloves, exited the room, placed the lancet into the sharps container and placed the glucometer on the medication cart. RN-B utilized hand sanitizer to wash her hands and failed to disinfect the glucometer.

On 6/23/21, at 11:03 When asked, RN-B indicated the glucometer was disinfected after all resident's blood sugars were checked and recorded with a sanitizing wipe and, she further stated the glucometer was placed in the medication cart drawer to dry until used again at 4 pm.

On 6/24/21, at 7:30 a.m. the director of nursing (DON)-A and DON-B indicated glucometers were expected to be disinfected with purple top sanitizing wipes after each resident use and stated upon hire nurses were educated on disinfection of the community glucose meters.

During a follow up interview 6/24/21, at 8:42 AM RN-B stated she received glucometer training and confirmed disinfection of the glucometers were part of the training. RN-B confirmed the meter should be cleaned between each resident and stated, "I did not do that yesterday." When asked why, RN-B stated she gets rushed and forgets, and further verified the glucometers were to be cleaned between each resident and failed to do that. RN-B further indicated sometimes she does clean them [glucose meter] between each resident and sometimes she does not and further

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indicate she disinfects the glucometer at least twice daily.

R6's physician orders dated 4/12/21, indicated blood sugar check four times daily.
R3's physician orders dated 8/26/20, indicated blood sugar check three times daily.
R1's physician orders dated 1/29/21, indicated blood sugar check four times daily.
R22's physician orders dated 4/12/21, indicated blood sugar check four times daily.

On 12/21/17, at 1:19 p.m. registered nurse (RN)-A stated staff were to clean the glucometer with Sani-Wipes (disinfecting wipes) before and after the use of the glucometer. The DON's verified not disinfecting the glucometer was not appropriate for the cleansing of the glucometers.

EvenCare ProView Healthcare Professional Operator's Manual Operator's Manual & In-Service Guide undated, indicated:
Glucose meters used in a clinical setting for testing multiple persons must be cleaned and disinfected between patients.
Disinfection Instruction: The meter must be disinfected between patient uses by wiping it with a CaviWipe towelette or EPA-registered disinfecting wipe in between tests and be cleaned prior to disinfecting. The disinfection process reduces the risk of transmitting infectious diseases if it is performed properly. Step 1. Before disinfecting, clean the meter as described in Cleaning Instructions above. Step 2. Wash hands with soap and water and put on single-use medical protective gloves. Step 3. Prepare the CaviWipes towelette or other EPA-registered disinfecting wipe. Take out a wipe from the container and follow the instructions on the

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package. If needed, squeeze the wipe slightly to remove the excess liquid. Step 4. Wipe the glucose meter thoroughly including the front, back and sides, and take care not to get any liquid in the test strip port and serial port. Do not wrap the meter in a wipe. Step 5. If using the CaviWipes towelette, allow to remain wet for two minutes. For other EPA registered disinfecting wipes, allow the surface of the meter to remain wet for the contact time listed on the disinfecting wipe's instructions for use. Dispose of wipe when finished. Step 6. After disinfection, user should take off gloves and wash hands thoroughly with soap and water before proceeding to the next patient.

Policy Titled Blood Glucose/Glucometer Cleaning Policy & Procedure and dated 1/18, indicated:
A. Glucometers shared by multiple patients will be thoroughly wiped with Super Sani-Cloth (purple top disinfectant wipe) and allowed to air dry after every use and between every patient.
1. use a fresh super Sani-cloth (purple disinfectant wipe) wipe each time the glucometer is used
2. wipe all surfaces, top, bottom, and sides. Glucometer must be visibly wet.
3. Allow treated surface to remain wet for 2 minutes
4. Let glucometer dry.
5. If a glucometer becomes visibly contaminated, use wipe to pre-clean prior to disinfecting.

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 06/23/2021. At the time of this survey, Lakeshore Inn Nursing Home was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/26/2021

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

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	245388	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**06/23/2021**

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K 000	Continued From page 1	K 000		

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101-5145, OR

By email to:
FM.HC.Inspections@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A detailed description of the corrective action taken or planned to correct the deficiency.

2. Address the measures that will be put in place to ensure the deficiency does not reoccur.

3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained.

4. Identify who is responsible for the corrective actions and monitoring of compliance.

5. The actual or proposed date for completion of the remedy.

Lakeshore Inn Nursing Home is a 1-story building with a partial basement. The building was constructed at 4 different times. The original building was constructed in 1960 and was determined to be of Type II(111) construction. In 1968, an addition was constructed to the South Wing that was determined to be of Type II(111) construction. In 1984, another addition was added to the South Wing and was determined to be Type II (111). In 1998, an addition was added to the East Wing and was determined to be Type

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K 000	Continued From page 2 II (111) construction. Because the original building and the 3 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a census of 23 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=D	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain proper exit discharge and transition to grade per NFPA 101 (	K 271	The areas in question will be fixed by raising the concrete and adding gravel underneath to maintain the proper	8/16/21

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K 271	Continued From page 3 2012 edition), Life Safety Code, sections 19.2.7, 7.1.7, 7.7. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 06/23/2021 between 09:00 AM to 01:00 PM, it was revealed that exit door, located in the LINK area of the facility, had a vertical transition to grade greater than one-half inch. This deficient condition was verified by the Maintenance Director.	K 271	transition. The Maintenance Director will monitor this area to ensure continued compliance. He will perform spot audits and report his findings to the Quality Assurance Committee at its quarterly meeting.	
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____________________ b) Who provided system test ____________________________ c) Water system supply source __________________________ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by:	K 353		8/16/21

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K 353	Continued From page 4 Based on observation and staff interview, the facility failed to maintain the sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, 9.7.6, 9.7.7, and 9.7.8, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1., 5.2.1. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 06/23/2021 between 09:00 AM to 01:00 PM, it was revealed that closets, located the Social Services Office and Physical Therapy Area, had items placed too close to sprinkler heads which could impede the proper operation of the sprinkler system This deficient condition was verified by the Maintenance Director.	K 353	The boxes in question were immediately moved to a location that was away from sprinkler heads. This was done before the Fire Marshall left the building. The Maintenance Director will monitor this area to ensure continued compliance. He will perform spot audits and report findings to the Quality Assurance Committee at its quarterly meeting.	
K 374 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal	K 374		8/16/21

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K 374	Continued From page 5 doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to inspect and maintain proper interspace width of the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3 and 8.5.4, and NFPA 80 (2010 edition), Standard for Fire Doors and Other Opening Protectives, section 6.3.1.7. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 06/23/2021 between 09:00 AM to 01:00 PM, it was revealed that the doors at the entrance of the Dining Room exhibited a gap between the two doors, when closed, greater than one-eighth inch This deficient condition was verified by the Maintenance Director.	K 374	A sweep was put on the door so that it maintains less than a 1/8th inch gap The Maintenance Director will monitor this area to ensure continued compliance. He will perform spot audits and report findings to the Quality Assurance Committee at its quarterly meeting.	
K 761 SS=D	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability.	K 761		8/16/21

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K 761	Continued From page 6 Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain, inspect and test the exit door in the East wing of the facility for operability per NFPA 101 (2012 edition), Life Safety Code, sections 7.2.1.7, 7.2.1.4.5.1 and NFPA 80 (2010 edition), sections 6.1, 6.1.4.2 This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 06/23/2021 between 09:00 AM to 01:00 PM, it was revealed that upon testing the exit door, East wing, required greater than thirty-pounds of force to open the door This deficient condition was verified by the Maintenance Director.	K 761	A sweep was added to the door to make it open with less than thirty pounds of force. The Maintenance Director will monitor this area to ensure continued compliance. He will perform spot audits and report findings to the Quality Assurance Committee at its quarterly meeting.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at	K 914		8/16/21

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K 914	Continued From page 7 intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain detailed information associated to receptacle testing in patient care rooms per NFPA 99 (2012 edition), Health Care Facilities Code, section(s) 6.3.3.2. This deficient condition could have an widespread impact on the residents within the facility. Findings include: On 06/23/2021 between 09:00 AM to 01:00 PM, it was revealed that electrical outlet testing documentation did not provide detailed testing information on the individual outlets tested in resident rooms. This deficient condition was verified by the Maintenance Director.	K 914	A master sheet of each outlet in the building has been created. All of the required annual testing will be completed utilizing this outlet master. The records will show, by outlet, the date of the test and the corresponding result. The Maintenance Director will monitor this area to ensure continued compliance. He will perform spot audits and report findings to the Quality Assurance Committee at its quarterly meeting.	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System	K 918		8/16/21

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K 918	Continued From page 8 Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on and staff interview, the facility failed to maintain facility emergency power supply systems and components per NFPA 99 (2012 edition), Health Care Facilities Code, section	K 918	During the pandemic, our generator maintenance provider got off of their schedule. This caused the batteries to be two days past the two year limit. They will	

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K 918	Continued From page 9 6.4.1.1.13, and NFPA 110 (2010), Standard for Emergency and Standby Power Systems, sections 5.6.4.5.1, A.5.6.4.5.1, 8.3 This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 06/23/2021 between 09:00 AM to 01:00 PM, it was revealed that the installation date of the battery for the emergency power supply system could not be determined. (Previously sited K-tag in 2019) 2. On 06/23/2021 between 09:00 AM to 01:00 PM, it was revealed that a remote generator status panel at the East Nurses Station is connected to, and displaying info for, a non-functional emergency power supply system. This deficient condition was verified by the Maintenance Director.	K 918	be getting the battery inspection and replacement back on the regular schedule and they will be clearly marking the dates the batteries were replaced. The remote generator panel at the East Nurses station has been modified so it no longer displays information that is visible to employees working at that nurses station. The Maintenance Director will monitor this area to ensure continued compliance. He will perform spot audits and report findings to the Quality Assurance Committee at its quarterly meeting.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power	K 920		8/16/21

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K 920	Continued From page 10 strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper management and implementation of power-strips per NFPA 101 (2012 edition), Life Safety Code, sections 10.5.1.1, 9.1, 9.1.1, and NFPA 70-2011 (2011 editions) sections 400-8. This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 06/23/2021 between 09:00 AM to 01:00 PM, it was revealed that daisy-chained power-strips were being used to power equipment in the East Wing - Med Room closet This deficient condition was verified by the Maintenance Director.	K 920	The power strips in question are no longer daisy chained. This was corrected prior to the Fire Marshall leaving the building. The Maintenance Director will monitor this area to ensure continued compliance. He will perform spot audits and report findings to the Quality Assurance Committee at its quarterly meeting.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and	K 923		8/23/21

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K 923	Continued From page 11 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections	K 923	The Med Gas storage closet on the East Wing has had a lock placed on the door. New signage has been created identifying this room as a storage space for Oxygen.	

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K 923	Continued From page 12 11.3.4, 11.6.2.3, 11.6.5 This deficient condition could have a widespread impact on the residents within the facility. Findings include: 1. On 06/23/2021 between 09:00 AM to 01:00 PM, it was revealed the East Wing - Med Gas storage closet was unsecured, had mixed storage of cylinders (empty / full), no cylinder separation, no empty / full signage. 2. On 06/23/2021 between 09:00 AM to 01:00 PM, it was revealed the South Wing - Med Room was being used for Med Gas (O2) storage. The room was not labeled appropriately, had mixed storage of cylinders (empty / full), no cylinder separation This deficient condition was verified by the Maintenance Director.	K 923	The cylinder's are separated and signage identifying tanks as either empty or full is being utilized. The storage room for the South Wing has been relocated to a locked room at the beginning of the wing. The room is labeled as a storage space for Oxygen, the cylinders are separated appropriately, and signage identifying tanks as either empty or full is being utilized. The Maintenance Director will monitor this area to ensure continued compliance. He will perform spot audits and report findings to the Quality Assurance Committee at its quarterly meeting.	

Electronically delivered
July 16, 2021

Administrator
Lakeshore Inn Nursing Home
108 8th Street Northwest
Waseca, MN 56093

Re: State Nursing Home Licensing Orders
Event ID: ZVFZ11

Dear Administrator:

The above facility was surveyed on June 21, 2021 through June 24, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00682	A. BUILDING: ____ B. WING ____	C 06/24/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 6/21/21 through 6/24/21, a licensing and complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you	2 000		

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2 000	Continued From page 1 have reviewed these orders and identify the date when they will be completed. The following complaint was found to be SUBSTANTIATED: H5388018C (MN67924, however NO licensing orders were issued. The following complaints were found to be UNSUBSTANTIATED: H5388019C (MN70612) H5388017C (MN65486) H5388016C (MN60288) Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please	2 000		

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2 000	Continued From page 2 enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21095	MN Rule 4658.0650 Subp. 4 Food Supplies; Storage of Nonperishable food Subp. 4. Storage of nonperishable food. Containers of nonperishable food must be stored a minimum of six inches above the floor in a manner that protects the food from splash and other contamination, and that permits easy cleaning of the storage area. Containers may be stored on equipment such as dollies, racks, or pallets, provided the equipment is easily movable and constructed to allow for easy cleaning. Nonperishable food and containers of nonperishable food must not be stored under exposed or unprotected sewer lines or similar sources of potential contamination. The storage of nonperishable food in toilet rooms or vestibules is prohibited. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21095	The Dietary manager and Kitchen	8/16/21

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21095	Continued From page 3 review, the facility failed to label opened containers of food, not sanitize a deep fat fryer in storage, and not sanitize the kitchen commercial can opener. These deficient practices had the potential to affect all 22 residents who received food from the kitchen. Findings include: During the tour of the kitchen on 6/22/21, at 9:36 a.m. with the on-duty facility cook (Cook)-A, the following food containers were found opened without an open date identified: Dry storage in the kitchen: Rice Krispies cereal, bread sticks, moldy hot dog buns, five pastries in a plastic serving box, bulk flour and sugar bins, and wild rice. Bulk dry storage in the storage room: carrot cake mix and panko crumbs stored in 6 quart buckets. The storage buckets had an opened date label of 5/1/20, however, Cook-A stated dry goods should be discarded after six months after opening. Refrigerator: three hamburger patties, wilted lettuce, five corn dogs, Alfredo Sauce, and Italian sausage. Freezer: three strawberry salads not covered or dated. During the kitchen tour it was also discovered that an electric countertop deep fryer in the storage room was filled with frying oil and was not cleaned or drained from oil before putting in storage. Cook-A stated not knowing how long the deep fryer had been in storage. Additionally, the commercial kitchen can opener had dried food on the opener knife.	21095	manager will reinforce the importance of following policy of labeling and dating foods, whereby all foods will be labeled and dated according to date procured, opened or prepared and perishable foods will be used within 7 days (with few exceptions for commercially packaged items). Dry goods will be used within 6 months This shall be completed in the form of mandatory inservice held by dietary director and licensed dietitian. The can opener will be washed through the dishwasher daily. The countertop deep fryer has been disassembled and sanitized and the fryer oil has been discarded. The outdated panko bread crumbs and outdated carrot cake mix have also been discarded. Dietary director and kitchen manager will conduct random audits to ensure compliance to policy. They will report their findings to the Quality Assurance Committee at its quarterly meeting.	

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21095	Continued From page 4 During an interview on 06/22/21, at 10:06 a.m. kitchen manager (KM)-A stated the kitchen has had a lot of trouble with outdates of opened food. KM-A stated it is a constant battle with staff to label opened food because of significant staff turnover. KM-A stated open food and beverages must be labeled with the opened date or discarded if not dated. The facility Policy & Procedure Manual from Becky Dorner & Associates, copy write 2000, pages 136-138, titled Food Storage, directed to keep foods safe with proper storage, all opened foods and beverages must be clearly labeled and dated of when it is opened. SUGGESTED METHOD OF CORRECTION: The dietary director (DD) and licensed dietician (LD) could re-educate dietary staff on the policies and procedures related to labeling and storage of foods as well as cleaning procedures for equipment used to prepare foods. The DM could conduct random audits to ensure compliance. The DM cold bring forth the audit results to the quality assessment (QA) committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21095		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and	21390		8/16/21

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21390	Continued From page 5 control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure multi-use glucometers (blood sugar monitor machines) were disinfected between resident use for 4 out of 9 diabetic residents (R1, R3, R6, R22) observed to have blood sugar checks. Findings include: On 6/23/21, at 10:52 a.m. registered nurse (RN)-B was observed to remove a glucometer from the top drawer of the south treatment medication cart and stated the facility utilized one glucometer per unit to obtain resident's blood sugars. RN-B entered R6's room with the facility's	21390	We have taken the following steps to ensure continued compliance in this area. We have reviewed and updated our policy on glucometer disinfecting. A glucometer will be provided for each diabetic resident and cleaned per policy. Glucometers will be kept in individual labeled zip lock bags and stored in medication or treatment carts or tote. Education will be provided to nursing staff via training memo on proper procedures and infection control standards related to	

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21390	Continued From page 6 communal glucometer device, a new lancet (finger stick device) and a test strip from the medication cart. RN-B donned gloves and utilized the lancet to obtain a blood drop and placed it on the glucometer strip in the machine. Once the glucometer reading registered, RN-B removed her gloves, exited the room, placed the lancet into a sharps container and placed the glucometer on the top of the medication cart. RN-B disinfected her hands and failed to disinfect the glucometer. On 6/23/21, at 10:55 a.m. RN-B was observed to wheel the medication cart to R3's room. RN-B picked up the unclean community glucometer, a lancet and a test strip and entered R3's room. RN-B donned gloves and obtained a blood sample with the lancet. RN-B placed the blood on the strip and obtained the blood sugar reading. RN-B removed her gloves, exited the room, placed the lancet into the sharps container and placed the glucometer on the medication cart. RN-B utilized hand sanitizer to wash her hands but was not observed to disinfect the glucometer. On 6/23/21, at 10:58 a.m. RN-B wheeled the medication cart to R1's room. RN-B picked up the unclean community glucometer, a lancet and a test strip and entered the doorway of R1's room. RN-B donned gloves and obtained a blood sample with the lancet. RN-B placed the blood on the strip and obtained the blood sugar reading. RN-B removed her gloves, exited the room, placed the lancet into the sharps container and placed the glucometer on the medication cart. RN-B utilized hand sanitizer to wash her hands but was not observed to disinfect the glucometer. On 6/23/21 at 11:00 a.m. RN-B was observed to wheel the medication cart to R22's room. RN-B	21390	sanitizing glucometers. Directors of Nursing or designee will perform spot checks in this area to ensure continued compliance. They will report their findings to the Quality Assurance Committee at its quarterly meeting.	

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21390	Continued From page 7	21390		

picked up the unclean community glucometer, a lancet and a test strip and entered R22's room. RN-B donned gloves and obtained a blood sample with the lancet. RN-B placed the blood on the strip and obtained the blood sugar reading. RN-B removed her gloves, exited the room, placed the lancet into the sharps container and placed the glucometer on the medication cart. RN-B utilized hand sanitizer to wash her hands and failed to disinfect the glucometer.

On 6/23/21, at 11:03 When asked, RN-B indicated the glucometer was disinfected after all resident's blood sugars were checked and recorded with a sanitizing wipe and, she further stated the glucometer was placed in the medication cart drawer to dry until used again at 4 pm.

On 6/24/21, at 7:30 a.m. the director of nursing (DON)-A and DON-B indicated glucometers were expected to be disinfected with purple top sanitizing wipes after each resident use and stated upon hire nurses were educated on disinfection of the community glucose meters.

During a follow up interview 6/24/21, at 8:42 AM RN-B stated she received glucometer training and confirmed disinfection of the glucometers were part of the training. RN-B confirmed the meter should be cleaned between each resident and stated, "I did not do that yesterday." When asked why, RN-B stated she gets rushed and forgets, and further verified the glucometers were to be cleaned between each resident and failed to do that. RN-B further indicated sometimes she does clean them [glucose meter] between each resident and sometimes she does not and further indicate she disinfects the glucometer at least twice daily.

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R6's physician orders dated 4/12/21, indicated blood sugar check four times daily.
R3's physician orders dated 8/26/20, indicated blood sugar check three times daily.
R1's physician orders dated 1/29/21, indicated blood sugar check four times daily.
R22's physician orders dated 4/12/21, indicated blood sugar check four times daily.

On 12/21/17, at 1:19 p.m. registered nurse (RN)-A stated staff were to clean the glucometer with Sani-Wipes (disinfecting wipes) before and after the use of the glucometer. The DON's verified not disinfecting the glucometer was not appropriate for the cleansing of the glucometers.

EvenCare ProView Healthcare Professional Operator's Manual Operator's Manual & In-Service Guide undated, indicated:
Glucose meters used in a clinical setting for testing multiple persons must be cleaned and disinfected between patients.
Disinfection Instruction: The meter must be disinfected between patient uses by wiping it with a CaviWipe towelette or EPA-registered disinfecting wipe in between tests and be cleaned prior to disinfecting. The disinfection process reduces the risk of transmitting infectious diseases if it is performed properly. Step 1. Before disinfecting, clean the meter as described in Cleaning Instructions above. Step 2. Wash hands with soap and water and put on single-use medical protective gloves. Step 3. Prepare the CaviWipes towelette or other EPA-registered disinfecting wipe. Take out a wipe from the container and follow the instructions on the package. If needed, squeeze the wipe slightly to remove the excess liquid. Step 4. Wipe the glucose meter thoroughly including the front, back

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and sides, and take care not to get any liquid in the test strip port and serial port. Do not wrap the meter in a wipe. Step 5. If using the CaviWipes towelette, allow to remain wet for two minutes. For other EPA registered disinfecting wipes, allow the surface of the meter to remain wet for the contact time listed on the disinfecting wipe's instructions for use. Dispose of wipe when finished. Step 6. After disinfection, user should take off gloves and wash hands thoroughly with soap and water before proceeding to the next patient.

Policy Titled Blood Glucose/Glucometer Cleaning Policy & Procedure and dated 1/18, indicated:
A. Glucometers shared by multiple patients will be thoroughly wiped with Super Sani-Cloth (purple top disinfectant wipe) and allowed to air dry after every use and between every patient.
1. use a fresh super Sani-cloth (purple disinfectant wipe) wipe each time the glucometer is used
2. wipe all surfaces, top, bottom, and sides. Glucometer must be visibly wet.
3. Allow treated surface to remain wet for 2 minutes
4. Let glucometer dry.
5. If a glucometer becomes visibly contaminated, use wipe to pre-clean prior to disinfecting.

SUGGESTED METHOD FOR CORRECTION:
The director of nursing (DON) or designee could re-educate nursing staff on policies related to proper procedures and infection control (IC) standards related to sanitizing the glucometer between resident glucometer testing. The DON or designee could conduct random audits to ensure compliance.. The DON could bring forth the audit results for the quality assurance (QA) committee to review.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21390	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty (21) days.	21390		
21615	MN Rule 4658.1340 Subp. 2 MedicineCabinet & Preparation Area;ScheduleII Subp. 2. Storage of Schedule II drugs. A nursing home must provide separately locked compartments, permanently affixed to the physical plant or medication cart for storage of controlled drugs listed in Minnesota Statutes, section 152.02, subdivision 3. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system for periodic reconciliation of controlled or narcotic medications in 1 of 1 emergency kit (E-Kit). This had the potential to affect any of the 22 residents present in the facility who may require controlled medications from the E-Kit and refrigerators. Findings include: On 6/22/21, at 2:15 p.m. a tour of the south unit medication room was conducted with registered nurse (RN)-A. Located within the locked medication room was a locked cabinet with an E-Kit. The E-kit was observed to have two yellow secured tags present and included lorazepam (an anti-anxiety medication/controlled substance), morphine (narcotic pain medication/controlled substance), and hydrocodone (a narcotic pain medication/controlled substance). RN-A indicated if the E-Kit was opened and medications were removed, nursing staff would remove the yellow	21615	We have taken the following steps to ensure continued compliance in this area. We have written and implemented a new policy on Emergency Kit reconciliation. Part of this policy utilizes an Emergency Kit reconciliation log. Licensed nurses will verify tag numbers and integrity of tags on refrigerated and non-refrigerated Emergency Kits at each shift change. Licensed nurses will be educated on policy by training memo. Directors of Nursing or designee will spot audit the Emergency Kit reconciliation log and the results will be reported to the Quality Assurance Committee at its quarterly meeting.	8/16/21

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tags (which locked the E-Kit) and replace with red tags to secure the E-Kit until the pharmacy came to change out the E-Kit. The tour further indicated a locked refrigerator on the south unit to contain an E-Kit. The E-kit was observed to have a yellow secure tag present and included 2 mg lorazepam vial and RN-A confirmed the lorazepam was not being reconciled. RN-A stated the pharmacy came to the facility weekly.

On 6/23/21, at 11:12 a.m. RN-B confirmed being aware the E-kit included lorazepam, hydrocodone, morphine, further confirmed nursing staff did not include the narcotic contents from the E-Kit with their narcotic counts. RN-B stated when medications were removed from the E-kit, the DON was notified.

On 6/24/21, at 7:30 a.m. the director of nursing (DON)-A and DON-B confirmed the E-kit was not reconciled daily, the DON's stated they were not aware of the medications in the E-kit and were not aware the E-Kits were to be reconciled.

On 6/25/21, at 8:15 a.m. via telephone interview the consultant pharmacist, she indicated the e-kits were expected to be inspected daily and ensured the E-kit tags were secured.

The policy titled, Controlled Substances dated 12/2012, included: Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together They must document and report any discrepancies to the Director of Nursing.

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and consulting pharmacist could review and revise policies and

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21615	Continued From page 12 procedures to ensure reconciliation of controlled substance medications stored in the E-Kit. Licensed nursing staff could be re-educated on the policies for reconciling controlled substance medications. The DON or designee, along with the pharmacist, could conduct routine audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21615		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and develop an intervention to accommodate needs and promote independence with the ability to perform hand hygiene and utilize the sink in the resident's shared bathroom for 1 of 1 resident (R223) reviewed for accommodation of needs. Findings include: R223's face sheet printed on 6/22/21, indicated	21810	We disagree with the surveyors finding in this area. We feel it was a one-time incident that in no way rises to a deficient practice. However, in the spirit of cooperation we have taken the following steps to ensure that we provide the highest level of care to our residents. All bathrooms were assessed to make sure resident needs are accommodated. We have reviewed our Accommodation of Needs policy. Staff has been re-educated	8/16/21

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21810	Continued From page 13 R223 was admitted on 6/21/21, with a diagnosis of infection due to right hip prosthesis (artificial body par). R223's care plan dated 6/23/21, identified resident needed help with bathing, bathroom use, to get ready in the morning and evening due to impaired mobility, infection and reimplantation of right hip joint. Interventions included time to do tasks, praise progress/effort, give rest periods during task, transfer with the help of two people bearing weight, use the bathroom with the help of one to two people to transfer on and off the toilet, change pad, do peri-care and adjust clothing, usually continent of bowel and bladder. Unable to walk, moves about the unit with the help of one person in the wheelchair, dress with the help of one person, hygiene/grooming tasks with the help of one person, wash hands and face after setup, staff assist with combing hair and with peri care, cleans own teeth and gums with set up. R223's care plan goal was to improve ability to participate in ADL' s in three months. R223's occupational therapy plan of care dated 6/22/21, identified oral hygiene set up or clean up assistance, helper sets up or cleans up, resident completes activity, helper assists only prior to or following the activity, and discharge plans to return home when able. R223's progress note dated 6/21/21, at 3:00 p.m. indicated R223 had no upper extremity loss of range of motion, alert and orientated, primary mode of locomotion was with a wheelchair. On 6/22/21, at 10:40 a.m. R223 stated she was admitted to the facility yesterday, and staff told her she could not use the shared bathroom, resident indicated she did not know why she was not able to use the bathroom. The shared	21810	on the Accommodation of Needs policy (CNA's, nurses, housekeeping,and Social Service) by a training memo that covered all of the appropriate topics. The Directors of Nursing or designee will perform spot audits to ensure resident rooms are set up to accommodate resident needs. The results of audits will be reviewed by the Quality Assurance Committee at its quarterly meeting.	

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bathroom was observed with a entrance blocked with an oxygen concentrator and commode located in front of the bathroom sink. R223 further indicated teeth were brushed and hair combed independently.

On 6/23/21, at 8:00 a.m. R223 entrance to the shared bathroom was observed and R223's bathroom doorway was blocked by an oxygen concentrator.

On 6/23/21, at 1:00 p.m. trained medical assistance (TMA)-A stated R223 did not use her bathroom, when asked why TMA-A indicated R22's room did not have space for her oxygen concentrator and commode, and therefore the items were placed in the shared bathroom. TMA-A further confirmed R223 would not be able to access the bathroom with R22's items in the bathroom.

On 6/23/21, at 1:10 p.m. RN-B indicated R223 used the bedside commode for toileting and does not have access to the bathroom due to R22's items in the bathroom.

On 6/23/21, at 2:43 p.m. interview with social services stated she assisted with R223's admission and was unaware the resident was not able to access her bathroom and further confirmed R223 should have access to the bathroom. Social services indicated she completed the admission interview and did not assess the shared bathroom at the time of admission.

On 6/24/21, at 8:08 a.m. interview with director of nursing (DON)-A and DON-B indicated residents should have access to the shared bathrooms and other resident's personal property should not be

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stored in the bathroom to limit a resident from entering the bathroom. R223's bathroom was observed with the DON's and acknowledged and confirmed R223 was not able to access the shared bathroom with R22's oxygen concentrator and commode that blocked R223's entrance and access to the sink. The DON's stated they expected all residents to have access to the shared bathroom and would expect residents to access the bathroom to wash hands and brush teeth.

On 6/24/21, at 9:44 a.m. an interview with the administrator indicated he was not aware R223 did not have access to the shared bathroom and expected the resident's bathroom to be clear of other residents' belongings and the others resident's oxygen concentrator should not block the bathroom entrance.

A facility policy regarding accommodations of needs was requested and not received.

SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure residents rooms are set up to accommodate their individual needs. The DON or designee could educate all appropriate staff to ensure these accommodations are met according to their activities of daily needs (ADL's). The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.

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21925	Continued From page 16	21925		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a written transfer notice was given to 1 of 1 residents (R22) upon transfer to the hospital. In addition, the facility failed to have a system in place to ensure residents/resident representatives were given written notice upon transfer. This deficient practice had the potential to affect all 23 residents residing in the facility.	21925	We are taking the following steps to ensure that we provide the best possible resident experience. Our Social Service Director has reviewed and revised policies and procedures to ensure proper documentation is in place for discharges and transfers. Nursing staff will complete a training memo on	8/16/21

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21925	Continued From page 17 R22's quarterly Minimum Data Set (MDS) assessment dated 6/7/21, indicated R22 was cognitively intact, had adequate hearing, impaired vision, clear speech, could make self understood and was able to understand. R22 required extensive assistance from one or two staff for bed mobility, transferring, dressing, toileting and hygiene. R22 did not walk. A progress note dated 4/6/21, at 11:32 a.m. indicated R22 was transferred by ambulance to a local hospital with stroke symptoms. Progress note dated 4/6/21, at 2:10 p.m. indicated R22 would be admitted to the hospital. During an interview on 6/24/21, at 1:31 p.m. the director of nursing (DON) stated they do not inform the resident or resident representative in writing when a resident required transfer. The DON was not aware this was required; stating she thought they just needed to enter a note in the resident's medical record that the resident representative was informed of the transfer. Facility did not have a policy for providing written notice of transfer. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and/or develop policy and procedures to include written notifications of transfers are provided to the resident and their representative prior to the transfer. The facility could educate staff on these policies and audit periodically to ensure compliance. The results of these audits could be brought forth to the quality assessment committee for review. TIME PERIOD FOR CORRECTION: Twenty One	21925	proper procedures for hospital transfers and discharges. The Social Service Director will spot audit this area to ensure continued compliance. She will report her findings to the Quality Assurance Committee at its quarterly meeting.	

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21925	Continued From page 18 (21) days	21925		