

# STATE LICENSING COMPLIANCE REPORT

**Report #:** # HL205685952C

**Date Concluded:** January 16, 2024

**Name, Address, and County of Facility**

**Investigated:**

Lakeside Generations Assisted Living  
441 William Avenue East  
Dassel, MN 55325  
Meeker County

**Facility Type:** Assisted Living Facility (ALF)

**Evaluator's Name:** Erin Johnson-Crosby, RN  
Special Investigator

The Minnesota Department of Health conducted a complaint investigation to determine compliance with state laws and rules governing the provision of care under Minnesota Statutes, Chapter 144G. The purpose of this complaint investigation was to review if facility policies and practices comply with applicable laws and rules. No maltreatment under Minnesota Statutes, Chapter 626 was alleged.

To view a copy of the correction orders, if any, please visit:

<https://www.health.state.mn.us/facilities/regulation/directory/provcompselect.html>, or call 651-201-4201 to be provided a copy via mail or email. If you are viewing this report on the MDH website, please see the attached state form.

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20568</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/16/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKESIDE GENERATIONS ASSISTED</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>441 WILLIAM AVENUE EAST DASSEL, MN 55325</b>
--	--

(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
--------------------	--	---------------	---	--------------------

0 000	<p><b>Initial Comments</b></p> <p>*****ATTENTION*****</p> <p><b>ASSISTED LIVING PROVIDER CORRECTION ORDER</b></p> <p>In accordance with Minnesota Statutes, section 144G.08 to 144G.95, these correction orders are issued pursuant to a complaint investigation.</p> <p>Determination of whether a violation is corrected requires compliance with all requirements provided at the statute number indicated below. When a Minnesota Statute contains several items, failure to comply with any of the items will be considered lack of compliance.</p> <p><b>INITIAL COMMENTS:</b></p> <p><b>#HL205685952C</b></p> <p>On January 16, 2024, the Minnesota Department of Health conducted a complaint investigation at the above provider, and the following correction orders are issued. At the time of the complaint investigation, there were 32 residents receiving services under the provider's Assisted Living license.</p> <p>The following correction order is issued for #HL205685952C, tag identification 2310.</p>	0 000	<p>Minnesota Department of Health is documenting the State Correction Orders using federal software. Tag numbers have been assigned to Minnesota State Statutes for Assisted Living Facilities. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state Statute number and the corresponding text of the state Statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings which are in violation of the state requirement after the statement, "This Minnesota requirement is not met as evidenced by." Following the evaluators ' findings is the Time Period for Correction.</p> <p><b>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.</b></p> <p><b>THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES.</b></p> <p><b>THE LETTER IN THE LEFT COLUMN IS USED FOR TRACKING PURPOSES AND REFLECTS THE SCOPE AND LEVEL</b></p>	
-------	---	-------	--	--

Minnesota Department of Health  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20568</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/16/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKESIDE GENERATIONS ASSISTED</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>441 WILLIAM AVENUE EAST DASSEL, MN 55325</b>
--	--

(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
0 000	Continued From page 1	0 000	ISSUED PURSUANT TO 144G.31 SUBDIVISION 1-3.	
02310 SS=G	<p><b>144G.91 Subd. 4 (a) Appropriate care and services</b></p> <p>(a) Residents have the right to care and assisted living services that are appropriate based on the resident's needs and according to an up-to-date service plan subject to accepted health care standards.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and record review, the licensee failed to ensure appropriate care and services were provided based on resident's needs and according to an up-to-date service plan and accepted health care standards for one of one (R1) resident. Facility staff failed to assess and update the plan of care for R1 following a noted change in condition and decline in mobility with increased need for staff assistance with transfers. In addition, R1's provider was not updated on his noted decline in mobility or change in condition and facility staff failed to coordinate transfer to the hospital for an evaluation and discharge to a skilled nursing facility.</p> <p>This practice resulted in a level three violation (a violation that harmed a resident's health or safety, not including serious injury, impairment, or death, or a violation that has the potential to lead to serious injury, impairment, or death) and was issued at an isolated scope (when one or a limited number of residents are affected or one or a limited number of staff are involved or the situation has occurred only occasionally).</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20568</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/16/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKESIDE GENERATIONS ASSISTED</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>441 WILLIAM AVENUE EAST DASSEL, MN 55325</b>
--	--

(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
02310	<p>Continued From page 2</p> <p>The findings include:</p> <p>R1's diagnoses included dementia, heart disease, and heart failure. R1's service plan dated January 10, 2023, indicated R1 received assistance with dressing, grooming, medication administration, escorts to meals, and toileting assistance.</p> <p>R1's 90 day assessment dated April 3, 2023, indicated R1 required reminders for transfers and was often independent with a walker for transfers. At times R1 would have increased fatigue and would require assist of one for transfers. R1 received stand by assist for ambulating. The assessment also indicated R1 received one assist for toileting.</p> <p>R1's progress notes indicated:</p> <ul style="list-style-type: none"> <li>-April 6, 2023, at 8:06 a.m., indicated R1 required assistance with activities of daily living (ADL)'s. R1 received assistance with toileting at times, but would also use the bathroom independently. R1 at times was able to ambulate on his own at times within his apartment but required standby by assist in the hallway. R1 has been using a wheelchair more often the last week to month. The assessment indicated R1's services were appropriate.</li> <li>- April 23, 2023, at 2:13 p.m., indicated R1 was not feeling well complaining of a sore throat and cough, was weak and shaky. R1 was found twice sitting in the bathroom unable to get back to the living room because he was too weak. R1 required a two person assist assist each time. R1's family member (FM) requested an order for cough medicine. An order was received for Dextromethorphan (cough medicine) every 8</li> </ul>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20568</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/16/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKESIDE GENERATIONS ASSISTED</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>441 WILLIAM AVENUE EAST DASSEL, MN 55325</b>
--	--

(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
02310	<p>Continued From page 3</p> <p>hours as needed (PRN). Facility staff questioned R1's FM to see if R1 should be sent to the emergency room. The note also indicated a FM would have to stay with R1 overnight to assist with transfers and told the FM R1 may need to be transferred to a skilled nursing facility.</p> <p>R1's record did not include an assessment of the R1's change in condition or level of assistance required by staff. No updates were made to R1's plan of care and no additional follow-up or monitoring was completed.</p> <p>-April 24, 2023, at 8:13 a.m., R1 had a temperature of 100.1, a moist non-productive cough, and slight wheezing to bilateral lower lobes. R1 required extensive assistance to sit up in bed and assist of two staff with a transfer belt for transferring in/out of wheelchair, toilet, and recliner. R1 was given acetaminophen and cough syrup.</p> <p>-April 24, 2023, at 9:15 a.m., the licensee received a call from a skilled nursing facility (SNF) which indicated the SNF would be able to admit R1 tomorrow if all the paperwork was completed. The note indicated R1's family member would be coming around noon and at that time would be updated about this information.</p> <p>R1's record lacked documentation of the family being notified of a potential transfer to a SNF and there was no documentation of notification to R1's provider of the ongoing observed change in condition.</p> <p>- April 24, 2023, at 12:00 p.m., R1's temperature was 99.1. R1 was sitting in the recliner and was sleepy. R1's record did not identify if R1's</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20568</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/16/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKESIDE GENERATIONS ASSISTED</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>441 WILLIAM AVENUE EAST DASSEL, MN 55325</b>
--	--

(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
02310	<p>Continued From page 4</p> <p>provider had been notified of symptoms or that R1 had a change in level of assistance provided by staff.</p> <p>-April 24, 2023, at 1:24 p.m., R1's FM decided to take R1 to the emergency room. R1 required two staff to transfer into the vehicle. R1 left in daughter's care.</p> <p>-April 25, 2023, at 12:47 p.m., the licensee was notified R1 would be discharged to a SNF and would be long term resident.</p> <p>-April 26, 2023, at 2:05 p.m., indicated R1 was discharged on April 25, 2023, to a SNF for long term placement. The family opted to take R1 to the emergency room on April 24, 2023, since he was acutely ill and was admitted. R1 had a slow progression in ADL's [activities of daily living] and mobility decline since admitting to the facility. R1's mobility level varied greatly but over the last few weeks. At times R1 was able to stand up will little to no assist to requiring extensive assist of one with standing to this past weekend required assist of two with transfers and inability to walk. The registered nurse (RN) had been working with the SNF for R1 to transfer due to the need for a higher level of care.</p> <p>R1's record did not include information regarding a conversation with R1 or R1's family member regarding possible discharge to a SNF. R1's record lacked assessments reflecting R1's change in condition with increased need for assistance with ADL's and decline in mobility.</p> <p>R1's discharge summary dated April 25, 2023, indicated R1's condition declined and was moved to a higher level of care. R1 was brought to the emergency room (ER) and admitted overnight</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20568</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/16/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKESIDE GENERATIONS ASSISTED</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>441 WILLIAM AVENUE EAST DASSEL, MN 55325</b>
--	--

(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
02310	<p>Continued From page 5</p> <p>and was discharged to a SNF. The summary indicated R1's alertness and fatigue level varied from day to day and transfer ability also varied day to day, over the last few days requiring assistance of two for transfers.</p> <p>On January 16, 2024, 12:30 p.m., Registered nurse (RN)-A was interviewed and stated R1's cares fluctuated greatly from being independent to requiring two assist, but confirmed R1's recent assessment dated April 3, 2023, did not reflect that change. RN-A verified she told R1's family that R1 could not return to the facility. RN-A stated she was aware progress notes and assessments were not as good as they could have been and has learned a lot since this discharge. RN-A stated R1's provider should have been contacted with R1's change in condition. RN-A thought the SNF had reached out to R1's family regarding the discharge to their facility.</p> <p>On January 19, 2024, at 9:30 a.m., FM-C stated they were informed on April 23, 2023, that R1 was not feeling well and they would have to stay overnight with him to help with transfers. FM-C stated on April 24, 2023, RN-A called FM-C in the morning regarding R1's symptoms but did not mention being discharged to a SNF the next day. FM-C arrived to the facility around noon and when she saw R1, she decided R1 should be taken to the emergency room. While taking R1 to the car, RN-A told FM-C, "you know he can't come back here." FM-C responded, "I am sure the hospital will admit him overnight," RN-A responded, "I mean never, we are at a breaking point here and things are about to burst." FM-C stated she did not know what was going on but was currently worried about R1's current medical issue. FM-C stated the licensee did not follow proper discharge procedures and left R1 and the</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20568</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/16/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKESIDE GENERATIONS ASSISTED</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>441 WILLIAM AVENUE EAST DASSEL, MN 55325</b>
--	--

(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
02310	<p>Continued From page 6</p> <p>family confused and frustrated on what they needed to do. FM-C stated R1 spent about four months at the SNF and currently resided in a different assisted living facility.</p> <p>The licensee's Transfer, Discharge, Discharge Planning, and Referral- AL, dated November 22, 2022, indicated the residents may be considered for transfer or discharge to another level of care if the following criteria apply including: Resident has an unstable medical condition that required more than part time assistance or intermittent health-related care; Resident requires more than minimal assistance with transfers or mobility assistance from staff person on a regular basis. When a resident meets any of the discharge criteria, the licensee will meet with the Resident and family to discuss appropriate placement options. We will work with the accepting facility for a smooth transition. A temporary increase in services may occur until proper placement occurs. This would include full change in condition assessments.</p> <p>The licensee's Initial, Ongoing and Change in Condition Assessment-Evaluation of Residents dated January 31, 2023, indicated the RN will complete a comprehensive assessment with a change in condition. The RN is responsible for monitoring residents for a change of condition. If a residents care needs have changed warranting aspects of the comprehensive assessment to be changed or has changes to service needs such as a need for more transfer assistance would require new comprehensive assessment.</p> <p>No further information was provided.</p> <p>TIME PERIOD FOR CORRECTION: Seven (7) days</p>	02310		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>20568</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/16/2024</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>LAKESIDE GENERATIONS ASSISTED</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>441 WILLIAM AVENUE EAST DASSEL, MN 55325</b>
--	--

(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