DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 12, 2024

Administrator
Lakeside Generations Health Care Center
439 William Avenue East
Dassel, MN 55325

RE: CCN: 245533
Cycle Start Date: February 28, 2024

Dear Administrator:

On April 9, 2024, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 13, 2024

Administrator
Lakeside Generations Health Care Center
439 William Avenue East
Dassel, MN 55325

RE: CCN: 245533
Cycle Start Date: February 28, 2024

Dear Administrator:

On February 28, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by May 28, 2024 (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 August 28, 2024 (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

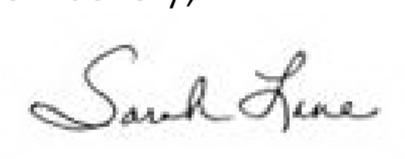
specified for compliance or the imposition of remedies.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245533	A. BUILDING _____ B. WING _____	C 02/28/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 2/25/24 through 2/28//24, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 2/25/24 through 2/28/24, 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 facility reported incident was reviewed and found in compliance: H55339942C/MN96241 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 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	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/20/2024

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

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F 000	Continued From page 1 validate substantial compliance with the regulations has been attained.	F 000		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure state agency survey results were posted and, in a location, easily visible and accessible to all residents, staff and visitors. This had the potential to affect all 42 residents living in the facility as well as any	F 577	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	3/31/24

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F 577	Continued From page 2 visitors or staff who wished to review this information. Findings include: On 02/28/24 at 0930 a.m., the area identified to house the past survey results binder was located across from the nursing station in a small cubby with one shelf about three feet off of the floor. The binder for past survey results was not located on the shelf. On 02/28/24 at 09:58 a.m., a resident council meeting was held with R6, R8, R19, R24, and R26 in attendance. The council members indicated they did not know where to find previous survey results. On 02/28/24 at 02:11 p.m., administrator stated survey results were kept in a plastic binder on a shelf across from nursing station. The binder was not visible when walking into the facility or while standing at the nursing desk. An obvious posting of the survey results availability was not observed. The administrator pointed to the shelf where the binder should have been and stated the binder should be there, however, the binder was not in the indicated location. Facility policy dated 5/21/18, with review date of 10/22/23, indicated survey results will be available in a readable form such as a binder or large print; facility will post these results in a place(s) that is/are readily accessible to residents, family members and the facility will post notice of availability of these reports in areas of the facility that are prominent and accessible to the public.	F 577	correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual. It is the policy of Cassia Lakeside Generations to comply with F577.To assure continued compliance, the following plan has been put into place; 1. Regarding Survey Binder: The facility moved the results of the past 3 years of surveys to place prominent and readily accessible to residents, family members and legal representatives of residents. The Health Department Survey Binder is located across from the nursing station. The facility posted an 8X10 notice in large lettering by front door and next to the binder across from the nurse s station. 2. Actions taken to identify placement of Survey Binder: Education completed with all facility staff on location of Health Survey Binder by March 31st. Education to be completed upon hire and ongoing. 3. Measures put into place to ensure deficient practice does not recur: Location of Health Survey Binder will be brought to Resident council On March 27th and on going X2 months. Facility will educate family members and legal representatives on May 14th during family council. 4. Responsible person: Administrator	

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F 577	Continued From page 3	F 577	/Designee Completion date for certification purposes is 3/31/24	
F 757 SS=E	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to identify diagnosis for use of medications for 4 of 6 residents (R4, R6, R16, and R34) reviewed for unnecessary medications and antibiotics. Findings include:	F 757	It is the policy of Cassia Lakeside Generations to comply with F757.To assure continued compliance, the following plan has been put into place; 1. How corrective action will be accomplished for the residents found to be affected: All residents affected by lack	3/31/24

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F 757	Continued From page 4 R6's face sheet identified diagnoses of hemiplegia and hemiparesis following a cerebral infarction (weakness and loss of movement following a stroke) on the left side, myocardial infarction (heart attack), diabetes mellitus type 2, hypertension (high blood pressure), hyperlipidemia (high fats in the blood), chronic pain, constipation, and muscle weakness. Review of the physician's order report dated 1/30/24 identified R6 received lisinopril 10 mg oral (PO) daily, rosuvastatin 10 mg PO daily, aspirin 81 mg daily, metoprolol succinate 25 mg PO daily and diclofenac sodium gel 1% topically as needed (PRN) three times a day, however these medications lacked diagnosis for use. R4's face sheet identified diagnoses of chronic diastolic (congestive) heart failure (a disease where the heart is unable to pump the blood through the body efficiently), a displaced fracture of upper end of left humerus (the long bone of the upper arm), pain in left arm, rheumatoid arthritis (chronic inflammatory disorder which can affect more than joints) of multiple sites with involvement of other organs and systems, heartburn, and dysphagia (difficulty in swallowing food or liquid). A review of the physician's orders report dated 2/14/24, included orders for acetaminophen 500 mg tablet, 1,000 mg orally once a day early morning between 2:00 a.m. to 3:00 a.m. The order, initiated on 2/1/24, lacked diagnosis for use. R4's orders also included the use of calazime paste; 0.44-20.6% one application twice daily to the left shoulder as needed. A faxed communication with the provider, dated 1/8/24, requested directions and indications for use. The	F 757	of diagnosis for use of medications were corrected on 2/29/24. 2. How the facility will identify other residents having the potential to be affected by same practice: IDT to review facility policy and improve process on entering diagnosis on a medication. HIM completed an audit on all resident charts for missing diagnosis for use of medications. 3. What measures will be put into place, or systemic changes made to ensure deficient practice will not recur. Re-education will be provided to staff who are responsible for entering orders on proper diagnosis on medications orders. Audits will be completed by HIM/designee 2X week X4 weeks and weekly thereafter to ensure that any orders missing a diagnosis are clarified or completed. 4. How the facility will monitor its corrective action to ensure that the deficient practice is being correct and not recur. Results of these audits will be taken to the QAPI committee for further recommendations. 5. Responsible person: HIM/Director of Nursing/designee Completion Date: 3/31/24	

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F 757	Continued From page 5 response directed staff to apply to left shoulder, however, lacked indication or diagnosis for use. R16's face sheet identified diagnoses of acute on chronic systolic (congestive) heart failure, type 2 diabetes mellitus (an illness which can cause high blood sugar) with diabetic polyneuropathy (a disease which can cause pain and tingling in legs related to damage from diabetes), acute pulmonary edema (fluid accumulation on the lungs), shortness of breath, other forms of shortness of breath, and essential hypertension (high blood pressure). A review of the physician's orders report, dated 2/14/24, identified an order from 11/13/23 for Anoro Ellipta (umeclidinium-vilanterol) 62.5-25 mcg/actuation one puff with inhalation once a day which lacked a diagnosis for use. An order for furosemide 20 mg twice a day, initiated on 2/5/24, also lacked diagnosis for use. R36's face sheet listed diagnoses included the following diagnoses: indwelling urethral catheter (a tube inserted into the bladder to drain urine), toxic encephalopathy (a disorder of the brain caused by exposure to toxic substances), benign prostatic hyperplasia (a condition in which the flow of urine is blocked due to the enlargement of prostate gland) with lower urinary tract symptoms, retention of urine, elevated white blood cell count and unspecified-leukocytosis (condition where your blood has too many white blood cells, which fight infections and diseases), a history of urinary (tract) infections, and history of Covid (a viral illness which can display with a variety of symptoms). R36's February Medication Administration Record	F 757		

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F 757	Continued From page 6 (MAR) indicated the following medications were ordered by the provider, however, lacked diagnoses or indication for use: amlodipine 5 mg one tablet daily, initiated 5/5/23; Bactrim DS (sulfamethoxazole-trimethoprim) tablet; 800-160 mg orally once a day, initiated 10/17/23, placed on hold 1/29/24, with resumption on 2/9/24, levothyroxine tablet 88 mcg one tablet daily, effective 2/9/24; metformin tablet 500 mg one tablet orally twice a day, initiated 1/23/23; cefdinir capsule 300 mg orally twice a day, initiated 1/29/24 through 2/8/24; and Macrobid (nitrofurantoin monohyd/m-cryst) 100 mg capsule orally twice a day, initiated 1/29/24 through 2/8/24. On 2/27/24 at 2:45 p.m., registered nurse (RN)-B stated when transcribing physician orders into the electronic medical administration record (eMAR) indication, dose, directions, route, resident name, and parameters should have been included. On 2/28/24 at 10:01 a.m., the director of nursing (DON) stated her expectation was to have indication (diagnosis) for use included in the order, and each order to be double checked by another nurse. DON stated it was important to include indications for medications, because the staff need to know why they were giving the medications to the residents. During a return call on 2/29/24 at 9:03 a.m., A&E Consultant Pharmacist stated he expected the following to be included in medication orders; medication name, dose, frequency administered and the duration. In addition, the provider information, patient information, and the diagnosis were to be included.	F 757		

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F 757	Continued From page 7 Facility policy Transcription of orders revised 2/12/24, indicated medication orders must include name of medication, dosage, route, and frequency. Each medication must also include a diagnosis for usage.	F 757		
F 851 SS=F	Payroll Based Journal CFR(s): 483.70(q)(1)-(5) §483.70(q) Mandatory submission of staffing information based on payroll data in a uniform format. Long-term care facilities must electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by CMS. §483.70(q)(1) Direct Care Staff. Direct Care Staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long term care facility (for example, housekeeping). §483.70(q)(2) Submission requirements. The facility must electronically submit to CMS complete and accurate direct care staffing information, including the following: (i) The category of work for each person on direct care staff (including, but not limited to, whether the individual is a registered nurse, licensed practical nurse, licensed vocational nurse,	F 851		3/15/24

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F 851	Continued From page 8 certified nursing assistant, therapist, or other type of medical personnel as specified by CMS); (ii) Resident census data; and (iii) Information on direct care staff turnover and tenure, and on the hours of care provided by each category of staff per resident per day (including, but not limited to, start date, end date (as applicable), and hours worked for each individual). §483.70(q)(3) Distinguishing employee from agency and contract staff. When reporting information about direct care staff, the facility must specify whether the individual is an employee of the facility, or is engaged by the facility under contract or through an agency. §483.70(q)(4) Data format. The facility must submit direct care staffing information in the uniform format specified by CMS. §483.70(q)(5) Submission schedule. The facility must submit direct care staffing information on the schedule specified by CMS, but no less frequently than quarterly. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit accurate and/or complete data for staffing information based on payroll and other verifiable and auditable data during 1 of 1 quarter reviewed (Quarter 4), to the Centers for Medicare and Medicaid Services (CMS), according to specifications established by CMS. Findings include:	F 851	It is the policy of Cassia Lakeside Generations to comply with F851.To assure continued compliance, the following plan has been put into place; 1. Regarding cited resident: Not applicable. 2. Actions taken to identify other potential residents having similar occurrences: Not applicable. 3. Measures put in place to ensure	

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	245533	A. BUILDING _____ B. WING _____	C 02/28/2024

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F 851	Continued From page 9 Payroll Based Journal (PBJ) Casper Report 1705D for FY (Fiscal Year) Quarter 4 2023 (July 1-September 30) identified the Metric of Excessively Low Weekend Staffing triggered. Daily staff schedules for weekend hours staffed during the reporting period were reviewed and compared to the facility simple PB&J spreadsheet. Comparative findings are listed below: On 7/1/23, the document titled Simple PB&J spreadsheet, provided by the facility, had a cumulative total of actual hours worked as 132.50 hours worked when tallied. A review of the automated total at the top of the spreadsheet indicated hours worked as 126.25 hours. On 7/2/23, the document titled Simple PB&J spreadsheet, provided by the facility, had a cumulative total of actual hours worked as 130.50 hours worked when tallied. A review of the automated total at the top of the spreadsheet indicated hours worked as 125.50 hours. On 7/8/23, the document titled Simple PB&J spreadsheet, provided by the facility, had a cumulative total of actual hours worked as 122.5 hours worked when tallied. A review of the automated total at the top of the spreadsheet indicated hours worked as 167.0 hours. On 7/9/23, the document titled Simple PB&J spreadsheet, provided by the facility, had a cumulative total of actual hours worked as 117.5 hours worked when tallied. A review of the automated total at the top of the spreadsheet indicated hours worked as 122.5 hours.	F 851	deficient practice does not recur: Education was completed on 3/15 with business office manager and director of nursing regarding proper communication of schedule changes for exempt direct care staff. 4. Effective implementation of actions will be monitored by: The administrator, director of nursing, and business office manager will audit total direct care hours provided to residents for three months to ensure PBJ submissions are complete and accurate. Results of these audits will be reviewed by the facility QAPI committee and they will make the decision if further monitoring/audits are recommended. 5. Those responsible to maintain compliance will be: The administrator, or designee, is responsible for maintain compliance. 6. Completion date for certification purposes only is: 3/15/2024	

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	245533	A. BUILDING _____ B. WING _____	C 02/28/2024

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F 851	Continued From page 10 The spreadsheet with actual hours worked had #'s through the dates from the period of 7/9/23-8/1/23. On 8/5/23, the document titled Simple PB&J spreadsheet, provided by the facility, had a cumulative total of actual hours worked as 115.5 hours worked when tallied. A review of the automated total at the top of the spreadsheet indicated hours worked as 123.5 hours. On 8/6/23, the document titled Simple PB&J spreadsheet, provided by the facility, had a cumulative total of actual hours worked as 124.50 hours worked when tallied. A review of the automated total at the top of the spreadsheet indicated hours worked as 124.50 hours. The spreadsheet with actual hours worked had #'s through the dates from the period of 8/10/23-8/31/23. On 9/2/23, the document titled Simple PB&J spreadsheet, provided by the facility, had a cumulative total of actual hours worked as 133.0 hours worked when tallied. A review of the automated total at the top of the spreadsheet indicated hours worked as 123.75 hours. On 9/3/23, the document titled Simple PB&J spreadsheet, provided by the facility, had a cumulative total of actual hours worked as 132.75 hours worked when tallied. A review of the automated total at the top of the spreadsheet indicated hours worked as 126.0 hours. On 9/9/23, the document titled Simple PB&J spreadsheet, provided by the facility, had a cumulative total of actual hours worked as 123.75	F 851		

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F 851	Continued From page 11 hours worked when tallied. A review of the automated total at the top of the spreadsheet indicated hours worked as 122.75 hours. The spreadsheet with actual hours worked had #'s through the dates from the period of 9/10/23-9/31/23. During interview on 2/28/24, at 12:19 p.m. the director of nursing stated the the completion and submission for the PB&J was completed at the corporate level. The facility provided schedules for the dates outlined as being triggered in the report, and information was reviewed. After exit from facility on 2/29/24, at 1:17 p.m. the director of clinical reimbursement provided the information requested on a spreadsheet titled Simple PB&J spreadsheet. The director stated she was unaware of any excessively low staff levels triggered by this reporting process. Upon request for related policy and procedures, the director stated they follow the guidelines established by CMS and do not have a separate policy for completion of this.	F 851		

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	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2024**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/27/2024. At the time of this survey, Lakeside Generations was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/20/2024

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

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Lakeside Generations is a 1-story building with no basement. The building was constructed at 4 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction. In 1978, an addition was constructed and was determined to be of Type II(111) construction. In 1984, an addition was constructed and was determined to be of Type II(111) construction. The most recent addition was constructed in 1993 and was determined to be of Type II(111) construction.	K 000		

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K 000	Continued From page 2 Because the original building and the 3 additions met the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=E	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the	K 324		3/13/24

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	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2024**

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K 324	Continued From page 3 corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Based on observation, a review of available documentation, and staff interview, the facility failed to install proper protection for cooking equipment per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.2.5.1, 19.3.2.5.3 (9). These deficient findings could have a patterned impact on the residents within the facility. Findings include: On 02/27/2024 between 9:00 and 10:30 AM, it was revealed by observation that a stoves in the PT Area and the Activities Area did not have a timer, not exceeding 120 minutes, that automatically deactivates the cooktop or range, independent of staff action. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 324	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Maintenance installed timers on each stove in the activity and therapy department. This had the potential to affect all residents. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. The Director of Maintenance will ensure that maintenance staff are trained on how to test each timer monthly. 3. What measures will be put into place,	

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	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2024**

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K 324	Continued From page 4	K 324	or systemic changes made, to ensure that the deficient practice will not recur. Monthly audits will be completed to ensure proper operation. 4. This deficiency was corrected on 3/13/24 5. Responsible person: Maintenance Director/designee	
K 351 SS=E	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.1, 19.3.5.4, and 9.7.1.1, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.6.6.1.	K 351	1. Action to correct the deficient practice: Food storage containers were removed in walk in freezer and are stored greater than 18 inches from sprinkler head. Shelves were removed from small storage closet keeping supplies greater	2/27/24

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	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2024**

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K 351	Continued From page 5 These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 02/27/2024 between 9:00 and 10:30 AM, it was revealed by observation that food storage containers were being stored in the walk-in freezer within 18 inches of the sprinkler head. 2. On 02/27/2024 between 9:00 and 10:30 AM, it was revealed by observation that nursing supplies were being stored in the small storage closet by the nurses station within 18 inches of the sprinkler head. An interview with the Maintenance Director and Administrator verified these deficient findings at the time of discovery.	K 351	than 18 inches from sprinkler head. This had the potential to affect all residents. 2. Measures that will be put in place to ensure that the deficient practice does not recur: Colored tape applied 18 inches below the sprinkler heads. Observations will be completed as part of the facilities ergonomics plan to not over stack shelves. 3. Completion date: 2/27/24 4. Person responsible: Director of maintenance or designee	
K 353 SS=E	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	K 353		2/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2024**

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

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K 353	Continued From page 6 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: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.2.2.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 02/27/2024 between 9:00 and 10:30 AM, it was revealed by observation that there were wires on top of the sprinkler pipes located above the ceiling in the East Wing. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 353	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Wires were removed from sprinkler pipes located above the ceiling in the East wing. Date sprinkler system last checked 2/12/24 by Director of Maintenance. Water supplied by City of Dassel. No residents were affected. 2. Measures that will be put in place to ensure that the deficient practice does not recur: Director of Maintenance will inspect sprinkler pipes when contractors or maintenance workers install or repair wiring to ensure proper placement. 3. Completion Date: 2/27/24 4. Person Responsible: Director of Maintenance or designee.	
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke	K 372		2/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245533	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/27/2024**

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K 372	Continued From page 7 barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.1, 19.3.7.3, 8.5.2.2, and 8.5.6.2. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/27/2024 between 9:00 and 10:30 AM, it was revealed by observation that there were blue wires going through the smoke barrier above the South Wing smoke barrier doors. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 372	1. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. The blue wires that were going through the smoke barrier on the South Wing were caulked with fire rated caulk. All residents have the potential to be affected.. 2. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Maintenance staff will be re-educated on maintaining smoke barriers. 3. Date corrected: 2/27/24 4. Responsible person: Director of Maintenance/designee	
K 911 SS=D	Electrical Systems - Other CFR(s): NFPA 101 Electrical Systems - Other List in the REMARKS section any NFPA 99 Chapter 6 Electrical Systems requirements that are not addressed by the provided K-Tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. Chapter 6 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain Electrical Systems per	K 911	1. How corrective action will be accomplished for those residents found to	2/27/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LAKESIDE GENERATIONS HEALTH CARE CENTER	**439 WILLIAM AVENUE EAST** **DASSEL, MN 55325**

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K 911	Continued From page 8 NFPA 99 (2012 edition), Health Care Facilities Code, section 6.3.2.2.1.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/27/2024 between 09:00 and 10:30 AM, it was revealed that electrical panel located in the Coffee Shop was not secured from being opened by unauthorized personnel. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.	K 911	have been affected by the deficient practice. A new lock was placed on the electrical panel located in the coffee shop. 2. Measures that will be put in place to ensure that the deficient practice does not recur: Director of Maintenance placed the key in a secure location to prevent access from unauthorized personnel. 3. Date corrected: 2/27/24 4. Responsible person: Director of Maintenance or designee	

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 245533	MULTIPLE CONSTRUCTION A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	DATE SURVEY COMPLETE: **2/27/2024**

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K 363	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor doors per NFPA 101 (2012 edition), Life Safety Code, section 19.3.6.3.10. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/27/2024 between 9:00 and 10:30 AM, it was revealed by observation the door to room 112 was propped open with an elastic band. Violation was corrected at the time of discovery. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.
K 712	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are

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

The above isolated deficiencies pose no actual harm to the residents

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K 712	Continued From Page 1 conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to conduct fire drills under varied times and conditions per NFPA 101 (2012 edition), Life Safety Code, sections 19.7.1.6, and 4.7.4. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 02/27/2024 between 9:00 and 10:30 AM, it was revealed by a review of available documentation that the facility was not varying the times of the fire drills throughout the year on each shift. An interview with the Maintenance Director and Administrator verified this deficient finding at the time of discovery.