



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 18, 2026

Administrator
LAKE MINNETONKA SHORES
4527 SHORELINE DRIVE
SPRING PARK, MN 55384

RE: CCN: 245210
Cycle Start Date: July 23, 2026

Dear Administrator:

On September 11, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads 'Sarah Lane'.

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

Email: sarah.lane@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 10, 2026

Administrator

Lake Minnetonka Shores

4527 Shoreline Drive

Spring Park, MN 55384

RE: CCN:245210

Cycle Start Date: July 23, 2026

Dear Administrator:

On July 23, 2026, 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, Regional Operations Supervisor

St. Cloud B District Office

Health Regulation Division

Minnesota Department of Health

4140 Thielman Lane

Saint Cloud, Minnesota 56301-4557

Email: judy.loecken@state.mn.us

Office: (320) 223-7300 Mobile: (320) 426-0175

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 **October 23, 2026** (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 **January 23, 2027** (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)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: <https://forms.web.health.state.mn.us/form/NHDisputeResolution>

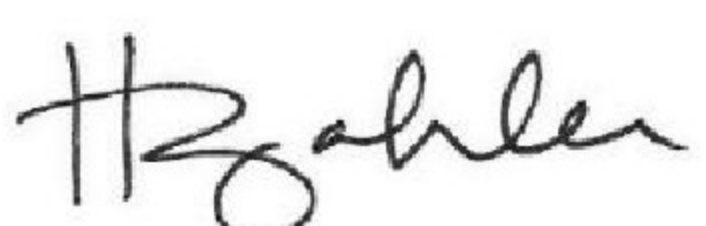
A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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,



Holly Zahler, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

Office: 651-201-4384

Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245210		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
NAME OF PROVIDER OR SUPPLIER LAKE MINNETONKA SHORES				STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE , SPRING PARK, Minnesota, 55384			
(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	
E0000	Initial Comments On 7/20/26 -7/23/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.		E0000			08/28/2026	
F0000	INITIAL COMMENTS On 7/20/26 -7/23/26, a standard recertification survey (S5210039) was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H52103110C (3056272). NO deficiencies were cited. 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 validate substantial compliance with the regulations has been attained.		F0000				
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care		F0684				

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245210	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER LAKE MINNETONKA SHORES			STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE , SPRING PARK, Minnesota, 55384	
(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
F0684 SS = D	Continued from page 1 Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interview, the facility failed to update the provider of a weight change per physician order for 1 of 5 residents (R3) reviewed for unnecessary medications. Findings include: R3's quarterly minimum data set (MDS) dated 4/28/26, indicated R3 was severely cognitively impaired, admitted on 7/31/24, and had the following diagnoses: heart failure (inability of the heart to pump efficiently), non-Alzheimer's dementia, and anxiety. R3's clinical physician orders dated 7/22/26, indicated the following orders: Daily weight. Updated NP (nurse practitioner) if weight increases by 3 pounds (LBS) in one day or 5LBS in one week. Order start date: 4/29/26. R3's weights and vitals dated 7/22/26, indicated the following weight fluctuations: On 5/17/26, R3 weighed 171.2lbs On 5/18/26, R3 weighed 174.2lbs, an increase of 5lbs. On 5/19/26, R3 weighed 170.6lbs, a decrease of 3.6lbs R3's medical record lacked any evidence the provider was ever updated per the provider order. On 7/22/26 at 7:43 a.m., the administrator confirmed the facility did not update the provider of the above noted weight changes per the order. On 7/22/26 at 3:00 p.m., the director of nursing (DON) confirmed the facility did not update the provider of the weight changes of R3 and stated they would have expected the staff to update the provider and document the communication in R3's chart. The DON stated the importance of updating	F0684	Continued from page 1 stated under the F-Tags. The facility reserves the right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board. Plan of Correction – F684: Quality of Care (§483.25) 1. Corrective Action for Affected Resident(s) Resident R3's weight orders, current weights and current condition were reviewed by the Clinical Administrator and Nurse Practitioner. Based on the current weight and clinical status, the provider did not give any new orders. R3's care plan was reviewed and updated to reflect risk of rapid weight changes due to CHF, daily weight tracking, and provider notification orders. 2. Corrective Actions for Residents with the Potential to be Affected The Clinical Administrator or licensed designee completed a 100% audit of all current residents with physician-ordered weight parameters to: Compare weight logs against provider notification parameters over the past 30 days. Verify that any weight gains or losses exceeding ordered parameters were properly reported to the primary care provider/NP and documented in the medical record. Ensure provider orders and care plans accurately reflect each resident's current weight monitoring needs. 3. Reoccurrence Prevention The facility policy Communication and Notification-Staff, Practitioners, and Resident Representatives was reviewed and remains current.	08/28/2026

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NAME OF PROVIDER OR SUPPLIER LAKE MINNETONKA SHORES				STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE , SPRING PARK, Minnesota, 55384			
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F0684 SS = D	Continued from page 2 the provider to prevent serious illness or harm to the resident. The facility Communication and Notification-Staff, Practitioners, and Resident Representatives last modified July 2024, indicated staff will notify the practitioner any time there is a: Significant change in clinical condition: including but not limited to a need to discontinue or change an existing form of treatment due to adverse consequences, or to initiate a new form of treatment Change in mental, psychological or behavioral patterns Any other time there has been a significant change in status from the plan of care Occurrence involving a fall or other type of occurrence requiring more than nursing intervention to address.			F0684	Continued from page 2 The Clinical Administrator will conduct a mandatory re-education for all licensed nursing staff (RNs and LPNs) and Trained Medication Aides (TMAs) on the Communication and Notification-Staff, Practitioners, and Resident Representatives policy, along with proper EHR documentation of the communication. 4. Quality Assurance & Monitoring (QAPI) The Clinical Administrator or Designee will audit weight logs and corresponding medical records for 100% of residents with weight parameters weekly for 4 weeks, then 5 residents bi-weekly for 4 weeks, and monthly thereafter for 3 months. Weights are accurately obtained and logged daily/as ordered. Any variance meeting notification parameters is reported to the primary care provider/NP immediately. Proper documentation is present in the clinical record. Audit findings will be presented by the Clinical Administrator at the quarterly QAPI meeting for review, evaluation, and further corrective action if necessary until substantial compliance is sustained. 5. Completion Date Date of Compliance: 8/28/2026		08/28/2026
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives			F0883	This Plan of Correction and the responses to each F-Tag are submitted to maintain certification in the Medicare and Medicaid programs and constitute a credible allegation of compliance. The written responses do not constitute an admission of noncompliance or agreement with any findings stated under the F-Tags. The facility reserves the right to dispute all findings and deficiencies in any appropriate forum, including in an independent dispute resolution, or, if appealable remedies are subsequently imposed, by timely appeal to the Departmental Appeals Board.		08/28/2026

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F0883 SS = D	Continued from page 3 education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.	F0883	Continued from page 3 Plan of Correction – F883: Influenza and Pneumococcal Immunizations (§483.80(d)(1)(2)) 1. Corrective Action for Affected Resident(s) Resident R13's immunization record, current health status, and pneumococcal recommendations were re-evaluated by the Clinical Coordinator and Clinical Administrator in coordination with the primary provider/NP and resident representative. Consent was confirmed, and the appropriate pneumococcal vaccine was ordered, administered, and documented in the EHR. 2. Corrective Actions for Residents with the Potential to be Affected The Clinical Administrator conducted a 100% audit of all current resident records to verify that all residents consenting to receive pneumococcal immunization have either received the vaccine, or have documented family/resident requests for delayed administration with a scheduled follow-up date. 3. Reoccurrence Prevention The facility Pneumococcal Vaccination Policy was reviewed and updated to Resident Vaccination Policy Mandatory re-education was conducted by the Clinical Administrator for all Licensed Nursing Staff and Clinical Coordinators on the Resident Vaccination Policy and documentation of delay. A template will be used for logging, tracking, and setting explicit follow-up tasks (30 days) when a resident/representative requests to delay vaccine administration. All residents or representatives requesting a delay in vaccination will have a documented follow-up date not to exceed 30 days, an assigned staff member	08/28/2026

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F0883 SS = D	Continued from page 4 This REQUIREMENT is NOT MET as evidenced by: Based on document review and interview the facility failed to ensure 1 of 5 residents (R13) was offered, educated and/or provided the pneumococcal vaccination series as recommended by the centers for disease control (CDC), who were reviewed for immunizations. Findings Include: A CDC Adult Immunization Schedule by age topic, dated 08/07/2025, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 50 years old had not received the complete series of pneumococcal vaccination (i.e., PPSV23, PCV20 and PCV13) or their history is unknown, then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20), 1 dose of PCV-15, or PCV-21. R13's annual Minimum Data Set (MDS) dated 6/19/26, indicated R13 was admitted 5/27/26, was severely cognitively impaired and had the following diagnoses: hypertension (HTN) (high blood pressure), benign prostatic hypertrophy (BPH) (enlarged prostate), and non-Alzheimer's dementia. R13's Order summary report dated 7/22/26, indicated the following physician order: May receive pneumococcal vaccinations if not already received. Order date: 5/27/26. R13's Minnesota Immunization Information Connection report dated 7/22/26, indicated R13 had received the following vaccinations: Pneumo-PCV13 (Pevnar 13) administered 8/29/17 Pneumo-PPSV23 (polysaccharide PSV23) administered 10/1/17 R13's Pneumococcal Vaccinations Consent form signed 5/27/26, indicated R13 had given consent and requested to receive the pneumococcal vaccination. R13's medical record lacked any evidence a vaccination was provided. On 7/22/26 at 3:00p.m., the director of nursing, working as the infection preventionist, confirmed the			F0883	Continued from page 4 responsible for follow-up, and documentation of the outcome of the follow-up discussion. The updated tracking process was integrated into the interdisciplinary admission checklist and new-hire nursing orientation. 4. Quality Assurance & Monitoring (QAPI) The Clinical Administrator/ Designee will conduct weekly audits of 100% of new admissions and 5 existing resident immunization records weekly for 4 weeks, then bi-weekly for 4 weeks, and monthly thereafter for 3 months to ensure: Immunization status and consent/refusal/deferral decisions are documented upon admission. Any deferred vaccinations have documented follow-up communications and timely administration once cleared. Audit findings will be submitted Quarterly to the QAPI Committee for review, tracking, and determination of ongoing compliance. 5. Completion Date Date of Compliance: 8/28/2026		08/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245210		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
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F0883 SS = D	Continued from page 5 vaccination had not been provided. The DON stated their expectation was the vaccinations should have been provided upon admission. The DON stated the family had wanted to wait until R13 was doing better to receive it; however, the facility should have followed up in 2-4 weeks after R13's admission. The DON stated the importance of providing vaccinations in a timely manner to prevent illness. The facilities Pneumococcal Vaccination Policy last revised 11-24, indicated each resident's pneumococcal immunizations status will be determined upon admission or soon thereafter if vaccination has occurred, the vaccination date will be documented in the resident's medical record.			F0883			08/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245210		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on July 23, 2026, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Lake Minnetonka Shores, 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. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145			K0000			08/28/2026

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 reverse for further 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.

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

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NAME OF PROVIDER OR SUPPLIER LAKE MINNETONKA SHORES				STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE , SPRING PARK, Minnesota, 55384			
(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
K0000 Bldg. 01	Continued from page 1 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. Building Info: Lake Minnetonka Shores is a 3-story building was determined to be of Type II (222) construction. Original construction in 1966 with additions in 1974 & 1982 and was determined to be of Type I (332). It has a partial basement and is fully protected throughout by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridor that is monitored for automatic fire department notification. In June of 2011, a 1-story building was constructed and determined to be of Type II (222) construction. It contains a basement and is attached to the existing nursing home, and is separated from an attached assisted living facility by a 2-hour fire-rated construction. The new addition is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors. It is monitored for automatic fire department notification. Because the original construction and additions are built of conforming construction, the facility will be surveyed as one building. The facility has a capacity of 60 beds and had a census of 51 at the time of the survey.			K0000			08/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245210		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
NAME OF PROVIDER OR SUPPLIER LAKE MINNETONKA SHORES				STREET ADDRESS, CITY, STATE, ZIP CODE 4527 SHORELINE DRIVE , SPRING PARK, Minnesota, 55384			
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K0000 Bldg. 01	Continued from page 2			K0000			08/28/2026
K0324 SS = F Bldg. 01	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: 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 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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to protect the cooking ventilation system in accordance with the NFPA 96, 6.2.3.3, 2011 Edition. This deficient finding could have a widespread impact on the residents within the facility. Findings Include: On 7/23/2026, between 10:35 AM, observations and staff interview revealed that the kitchen hood filters were not properly sealed leaving a 1/4" gap between the filters. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0324	Cooking Facilities NFPA 96, 6.2.3.3 Deficiency K0324 PHS Culinary Director and Environmental Services Director will ensure filters are properly sealed through periodic education and inspection. A safety checklist will be posted for all culinary staff with an explanation of the code. PHS Culinary Director will supply name, date and time of re-installing filters.		08/28/2026

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K0321 SS = D Bldg. 01	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed protect hazardous areas in accordance with the Life Safety Code NFPA 101 - 2012 edition 19.3.2.1. This deficient finding could have a moderate impact on the residents within the facility. Findings Include:			K0321	Hazardous Areas - Enclosure CFR(s): NFPA 101 Deficiency K0321 Two penetrations at the deck within the boiler room have been properly sealed for a 1 hour fire rating and will be re-inspected annually. A reoccurring task has been developed in PHS task management system, Tels. Environmental Services Director will be responsible for completing this task annually.		08/28/2026

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K0321 SS = D Bldg. 01	Continued from page 4 On 7/23/2026, at 9:43 AM, observations and staff interview revealed that there were two penetrations at the deck within the Boiler Room that were not properly sealed to maintain a 1 hour rating. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0321			08/28/2026
K0353 SS = D Bldg. 01	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 STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 25 (2011 edition) (5.2.2.2). This deficient finding could have a moderate impact on the residents within the facility. Findings include: On 7/23/2026, at 9:40 AM, it was revealed by observation that in the Laundry Room and in the Boiler Room, there were wires in contact with the sprinkler system. An interview with the Maintenance Director verified this deficient finding at the time of discovery.			K0353	Sprinkler System - Maintenance and Testing NFPA 25 5.2.2.2 Deficiency K0353 Wires in contact with the sprinkler system have been re-located in both laundry and boiler room. A reoccurring task has been developed in PHS task management system, Tels. Environmental Services Director will be responsible for completing this task bi-annually.		08/28/2026