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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4P10

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00271

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245210**

2.STATE VENDOR OR MEDICAID NO.
(L2) **172043100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE MINNETONKA SHORES**
(L4) **4527 SHORELINE DRIVE**
(L5) **SPRING PARK, MN** (L6) **55384**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/03/2010**

6. DATE OF SURVEY **09/28/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **145** (L18)

13.Total Certified Beds **145** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	145			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fisher, Unit Supervisor 09/28/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 10/11/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/28/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245210
October 12, 2015

Mr. Rob Lahammer, Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, Minnesota 55384

Dear Mr. Lahammer:

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

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

Effective September 22, 2015 the above facility is certified for or recommended for:

145 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 145 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245210
October 12, 2015

Mr. Rob Lahammer, Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, Minnesota 55384

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

Effective September 22, 2015 the above facility is certified for or recommended for:

145 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 145 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
October 12, 2015

Mr. Rob Lahammer, Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, Minnesota 55384

RE: Project Number S5210024

Dear Mr. Lahammer:

On August 27, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 13, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 28, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 13, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 22, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 13, 2015, effective September 22, 2015 and therefore remedies outlined in our letter to you dated August 27, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245210	A. Building B. Wing	9/28/2015

Name of Facility	Street Address, City, State, Zip Code
LAKE MINNETONKA SHORES	4527 SHORELINE DRIVE SPRING PARK, MN 55384

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **09/22/2015**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **09/22/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **09/22/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/22/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **09/22/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/22/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	JS/KJ	10/12/2015	33925	09/28/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/13/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 4P10

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00271

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245210**

2.STATE VENDOR OR MEDICAID NO.
(L2) **172043100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE MINNETONKA SHORES**
(L4) **4527 SHORELINE DRIVE**
(L5) **SPRING PARK, MN** (L6) **55384**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **06/03/2010**

6. DATE OF SURVEY **08/13/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **145** (L18)

13.Total Certified Beds **145** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	145			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Austin Fry, HFE NE II — 09/03/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 09/18/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS
Posted 09/28/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 27, 2015

Mr. Rob Lahammer, Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, Minnesota 55384

RE: Project Number S5210024

Dear Mr. Lahammer:

On August 13, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
Health Regulation Division
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 22, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A

Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by November 13, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by February 13, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245210	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA SHORES	4527 SHORELINE DRIVE SPRING PARK, MN 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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 7 residents (R285, and R3) observed for dignity were spoken to in a dignified manner. Findings include: R285's admission Minimum Data Set (MDS) dated 7/29/15, identified the resident had no cognitive impairment. During observation on 8/10/15, at 3:36 p.m. R285 was laying in bed, when nursing assistant (NA)-A	F 241	F 241 Dignity and Respect of Individuality 1. Corrective Action: NAR A and RN E were corrected on not using terms of endearment. 2. Corrective Action as it relates to Others: An inservice will be scheduled for the week of 9/7/15 at each Standup meeting to reach all Nurse/TMA/RA/Housekeeping Maintenance employees regarding our policy on Dignity with residents rights; to be called the name which is preferred by	9/22/15

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

Electronically Signed | 09/02/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245210	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA SHORES	4527 SHORELINE DRIVE SPRING PARK, MN 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
F 241	Continued From page 1 entered the room to obtain R285's vital signs. NA-A began to interact with R285, and was referring to the resident as "sweety" and "honey" on several occasions during the interaction. When NA-A went to remove the blood pressure cuff from R285's right arm she stated, "alright hun [honey]" as she lifted R285's arm up to remove the cuff. During interview on 8/10/15, at 3:45 p.m. R285 stated several of the staff at the facility call her different names (like "honey" or "dear") when they assist her with cares. R285 stated she did not want to be called honey or dear, and stated, "It's condescending [when staff refer to her not using her name]." During interview on 8/12/15, at 1:19 p.m. NA-A stated R285 did not have any preferences she was aware of to not be called those names, and added residents should be called by their name, "You shouldn't call them 'honey' or 'sweetheart'." However, NA-A stated she called everybody "honey", but was trying to break the habit and, "It's a slip up." During interview on 8/12/15, at 1:38 p.m. registered nurse (RN)-A stated R285 did not have a preference to be called by anything other than her name. R3 admission MDS dated 7/22/15, indicated the resident had severe cognitive impairment and had long and short term memory loss. R3 was observed on 8/12/15, at 7:28 a.m. during medication administration with RN-E. RN-E placed R3's medication on a spoon, placed the	F 241	the resident. This will be reviewed with each new employee on hire and yearly at the Annual Training Fair. 3. Reoccurrence will be prevented by: The Household Coordinator or designee will audit 2x per week for compliance by visually observing cares and listening for terms of endearment. 4. The Correction will by monitored by: a. The audits will be given to the Clinical Administrator for review b. The Clinical Coordinator will present to QA team to review. QA will determine frequency of audits. c. The Clinical Administrator will be responsible for compliance 5. Date of Completion: 9/22/15	

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	245210	A. BUILDING _____ B. WING _____	08/13/2015

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F 241	Continued From page 2 pills one by one into R3's mouth, and held up a glass of water with a straw to the resident lips and stated, "Were going to do a straw today dear." After completing the oral medications, RN-E instructed R3 on how to complete the two inhaler medications, stating, "We got one more dear," between inhalers. After the inhaler, R3 was instructed to gargle the water to rinse her mouth. RN-E stated to the resident, "Here honey, I'll help you," while assisting the resident with the glass of water. During interview on 8/12/15, at 1:38 p.m. registered nurse (RN)-A stated, staff should only be using terms of endearment with residents, "If its alright with the patient." A facility Dignity policy dated 10/04, identified, "It is the policy of Presbyterian Homes and Services that resident are cared for in a manner and in an environment that promotes maintenance and/or enhancement of each resident's quality of life... All staff will be trained in Resident Rights, Privacy, and Dignity upon hire and annually."	F 241		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nail care was provided for 1 of 3 residents (R201) who required limited staff assistance with activities of daily	F 311	F 311 Treatment/Services to Improve/Maintain ADLs 1. Corrective Action: R201 had his nails	9/22/15

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F 311	Continued From page 3 living (ADL). Findings include: R201's annual Minimum Data Set (MDS) dated 5/26/15, identified R201 had moderate cognitive impairment, and required limited assistance from staff to complete personal hygiene. R201's care plan dated 6/9/15, identified R201 had a, "ADL Self Care Performance Deficit," and required, "1 staff participation with personal hygiene..." There was no specific time frame in the care plan that identified the frequency of assistance with personal hygiene. During observation on 8/11/15, at 9:05 a.m. R201 was seated in a wheelchair in the commons area reading a newspaper. R201 had long fingernails on both hands, with a dark substance noted underneath several of the nails. R201 stated he did not like his fingernails that long and, "Would normally keep them a little shorter." During additional observations on 8/12/15, at 7:04 a.m. and 8/13/15, at 9:31 a.m., R201 continued to have long, dirty fingernails. During interview on 8/13/15, at 9:33 a.m. nursing assistant (NA)-B stated R201 needed help with cutting his nails, and they should be trimmed on his bath day (Sunday) or when staff notice they were getting long. NA-B observed R201's fingernails at this time and stated they needed to be trimmed and cleaned. During interview on 8/13/15, at 9:33 a.m. licensed practical nurse (LPN)-A observed R201's fingernails and stated nail care was completed once a week on bath days, and R201's fingernails	F 311	clipped and cleaned right away. R69 had her face shaved. 2. Corrective Action as it applies to Others: An inservice will be scheduled for the week of 9/7/15 at each StandUp to reach all Nurse/TMA/RA regarding the policy of nail care and grooming. 3. Reoccurrence will be prevented by: The Household Coordinator or designee will audit daily each resident who is scheduled for bath cares to ensure nails are completed when bathing. 2x per week audits will be completed on 3 residents for compliance by visually observing cares for shaving. 4. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator and Administrator for review. b. Clinical Administrator will report audits to the QA Team. QA will determine frequency of audits. c. The Clinical Administrator will be responsible for compliance. 5. Date of Completion: 9/22/15	

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F 311	Continued From page 4 should have been cleaned and trimmed to his preference. LPN-A stated she had recently been approached by several family members who had expressed concerns about their loved ones' grooming not being completed in a timely manner. The facility Resident Care policy dated 12/14, instructed, "Every resident to have A.M. [morning] and HS [bedtime] cares done daily or as the resident desires...". The policy did not identify when nail care should be completed for a resident.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine grooming for 1 of 1 residents (R69) who was dependent upon staff for activities of daily living (ADLs), and had unshaven facial hair. Findings include: R69's quarterly Minimum Data Set (MDS) dated 7/15/15, identified R69 had severe cognitive impairment, and required extensive assistance to complete personal hygiene.	F 312	F 312 ADL Care Provided for Dependent Residents 1. Corrective Action: R201 had his nails clipped and cleaned right away. R69 had her face shaved. 2. Corrective Action as it applies to Others: An inservice will be scheduled for the week of 9/7/15 at each StandUp to reach all Nurse/TMA/RA regarding the policy of nail care and grooming.	9/22/15

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F 312	Continued From page 5 R69's care plan revised 7/14/2015, identified R69's ADL self-care performance deficit, and included R69 required one staff assistance with personal hygiene. During observation on 8/11/2015, at 8:20 a.m. R69 was seated in a wheel chair in the dining room, dozing off during the breakfast meal. R69 was appropriately and neatly dressed, but had noticeably visible unshaven facial hair on her chin. During observation on 8/12/15 at 7:23 a.m. and 8/13/2015 at 9:28 a.m., R69 continued to have unshaven, visible facial hair. During interview on 8/11/2015, at 1:20 p.m. family member (FM)-B stated R69 had brought an electric razor into the facility specifically for staff to use to assist R69 to remove her facial hair, however, FM-B believed the shaver went missing but stated, "They still should be trimming [R69]'s facial hair." During interview on 8/13/2015, at 9:35 a.m. nursing assistant (NA)-D stated R69 required staff assistance to get up in the morning, and R69, "Was confused and you have to keep telling her what you are doing." NA-D stated staff should groom her facial hair daily and as needed, and not just on her bath day. During the interview, R69 was seated in a wheel chair in the dining area, and NA-D acknowledged the unshaven facial hair on R69's chin. During interview on 8/13/2015, at 2:08 p.m. registered nurse (RN)-C stated she would expect facial hair to be removed in the morning as part of routine resident cares. During interview on 8/13/2015, at 2:12 p.m.	F 312	3. Reoccurrence will be prevented by: The Household Coordinator or designee will audit daily each resident who is scheduled for bath cares to ensure nails are completed when bathing. 2x per week audits will be completed on 3 residents for compliance by visually observing cares for shaving. 4. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator and Administrator for review. b. Clinical Administrator will report audits to the QA Team. QA will determine frequency of audits. c. The Clinical Administrator will be responsible for compliance. 5. Date of Completion: 9/22/15	

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F 312	Continued From page 6 household coordinator (HHC)-A stated R69 was dependent upon staff for her cares, and stated, "It is my expectation that staff ...be using the shaver as often as needed." A facility policy titled Resident Care dated 12/14, directed every resident to have morning and evening cares done daily. "As the resident desires and per the resident plan of care."	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess for the safe use of a grab bar which did not meet FDA (Federal Drug Administration) guidelines to prevent entrapment for 1 of 1 residents (R78) reviewed for accidents and hazards related to a large gap between the mattress and grab bar. Findings include: R78's significant change Minimum Data Set (MDS) dated 5/22/15, identified R78 had severe cognitive impairment and required extensive assistance with bed mobility.	F 323	F323 Free of Accident Hazards/Supervision/Devices 1. Corrective Action: Mattress was removed from R78's bed and a correct size mattress placed. 2. Corrective Action as it Applies to Others: All beds were reviewed/audited for Mattress and Physical Device for any area of potential entrapment. Any mattress or side rail not meeting the FDA standards will be removed. A review of the Physical Device Policy will be reviewed at Stand Up the week of 9/7/15 with	9/22/15

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F 323	Continued From page 7 During observation of R78's bed on 8/11/15, at 8:19 a.m. a perimeter mattress was in use along with bilateral grab bars (metal and plastic bars used to help with bed mobility) which were fixed to the bed. The mattress of the bed moved easily when slight pressure was applied to it, leaving a large gap (approximately 6-7 inches in size) exposed between the grab bar and mattress, which is identified as "Zone 3" of the FDA guidelines (area between the inside surface of the rail and the mattress compressed by the weight of a patient's head). R78's medical record did not identified if R78 had been assessed for the safe use of the perimeter mattress that created a large gap between the grab bar and mattress which could cause entrapment if R78 attempted to exit the bed by herself. The Guidance for Industry and FDA (Federal Drug Administration) Staff Hospital Bed System Dimensional and Assessment Guidance to Reduce Entrapment manual dated 3/10/06, identified Zone 3 as the area, "between the inside surface of the rail and the mattress compressed by the weight of a patient's head. The space should be small enough to prevent head entrapment when taking into account the mattress compressibility, any lateral shift of the mattress or rail ... HBSW [Hospital Bed Safety Workgroup] and IEC [International Electrotechnical Commission] recommend a dimension of less than 120 mm [millimeters] [4 3/4 inches] ... FDA is recommending a dimensional limit of less than 120 mm [4 3/4 inches] for the area between the inside of the surface of the rail and the compressed mattress."	F 323	RN/LPN/TMA/RA, Housekeepers and Maintenance staff. Each mattress placed will be ordered by the size of the bed for which the mattress is to be placed. Maintenance will deliver the mattress. The physical device or mattress reviewed by the Clinical or Household prior to placing on the bed to make sure the mattress is of proper sizing for the bed. On a weekend of an evening shift it will be the designee of the charge nurse. A Physical Device assessment will be completed prior to placement. 3. Reoccurrence will be prevented by: An audit will be done of all beds monthly on Environmental Rounds by Household Coordinators or designee to ensure all mattresses are of proper fit. Frontline staff will with daily cares check the mattress for proper fit. 4. The Correction will by monitored by: a. The Audits will be given to the Clinical Administrator and Administrator for review. b. Administrator will report audits to the QA Team. QA will determine frequency of audits. c. The Administrator will be responsible for compliance. 5. Date of Completion: 9/22/15	

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F 323	Continued From page 8 During interview on 8/12/15, at 8:34 a.m. licensed practical nurse (LPN)-B stated R78 had been using the perimeter mattress because she had tried to get up out and fallen from the bed on 7/30/15. LPN-B stated R78 used bilateral grab bars which were fixed to the bed to assist with bed mobility. On 8/12/15, At 8:39 a.m. LPN-B measured R78's bed with the large gap between the mattress and grab bar, and stated the gap was, "Just about 6.2 inches." LPN-B stated R78 could become entrapped in the large gap between the mattress and grab bar and stated, "It's a safety issue for sure." During interview on 8/12/15, at 8:42 a.m. registered nurse (RN)-B observed R78's bed and stated R78 had been using the mattress since 7/30/15, when she fell out of her bed. RN-B stated R78 was able to get out of bed on her own at times, and the large gap between the mattress and grab bar was a safety concern because R78 could, "Fall in there" and "Have injury." RN-B measured the large gap between the mattress and grab bar and stated the gap was, "5 -1/2 inches." RN-B stated no assessment had been completed to ensure R78 was safe with using the perimeter mattress which left a large gap between the grab bar and mattress, and stated "We need to change it [the mattress]." The facility Physical Device Policy dated 1/2010, identified when a residents physical device is changed, "A new physical device assessment tool will be completed... All side rails on the resident bed will meet the FDA guidelines for safety."	F 323		
F 425	483.60(a),(b) PHARMACEUTICAL SVC -	F 425		9/22/15

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F 425 SS=D	Continued From page 9 ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 7 residents (R3) observed during medication pass was provided medication according to manufacturer instructions to ensure the adequate dosing of each medication. Findings include: During observation of medication administration on 8/12/15, at 7:28 a.m. registered nurse (RN)-E prepared medications for R3 at a mobile cart in the hallway. The medications included dosing	F 425	F425 Pharmaceutical SVC-Accurate Procedures 1. Corrective Action: RN E was corrected regarding use of Advair Inhaler. RN E was corrected regarding the removal of the Lidocaine patch. 2. Corrective Action as it applies to Others: A TMA/RN/LPN staff meeting will be held during the week of 9/7/15. Proper administration of medications as hand held inhalers and eye drops. Lidocaine	

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F 425	Continued From page 10 from an Advair Diskus inhaler (medication used to treat asthma and COPD [chronic obstructive pulmonary disease]), a Spiriva HandiHaler (inhaled medication used to prevent bronchospasm [closing of the airway]), and the application of a new Lidocaine transdermal patch (used to treat localized pain). RN-E approached R3 to administer the medications, held the Advair inhaler in her hands, and instructed R3 to breath in the medication. RN-E then activated the Advair inhaler, and administered it to R3. RN-E then picked up the Spiriva inhaler, provided instruction to R3 to breath in the medication, and activated the inhaler releasing the medication. RN-E did not instruct, encourage, or have R3 exhale deeply prior to administering either of the inhalant medications. RN-E then assisted R3 to lean forward in her chair to apply a new Lidocaine transdermal patch to her lower back. RN-E lifted up the back of R3's shirt which exposed a large white Lidocaine patch already applied to R3's lower back. RN-E removed the old patch, discarded it in the trash can, and applied the new patch she had prepared to the same location on her lower back. During interview on 8/12/15, at 7:47 a.m. RN-E stated she reviewed R3's current physician orders and the old Lidocaine patch should have been removed the night before (8/11/15), as directed by the packaging instructions ["Apply patches only once for up to 12 hours in a 24-hour period (12 hours on and 12 hours off)".]. RN-E stated she did not instruct or encourage R3 to exhale prior to the administration of her inhalant medications because she "gets so confused", but added it is best practice to have residents exhale deeply prior to taking inhalant medication because, "You get more [medication] in the	F 425	patch instruction to as to how to place in Point Click Care for proper administration and removal. Alternate placement of patches will be discussed for transdermal application. TMAs will review this yearly at Med Competency which is mandatory for all TMAs. 3. Reoccurrence will be prevented by: A Medication Administration Audit will be conducted randomly 2 times weekly of evenings and day shift on each household. These audits will be completed by the Clinical Coordinator or the designee. Lidocaine patches will be checked during this audit as well for proper instruction and removal. 4. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator and Administrator for review. b. Clinical Administrator will report audits to the QA team. QA will determine the frequency of audits. c. The Clinical Administrator will be responsible for compliance.	

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F 425	Continued From page 11 lungs." The undated Advair Diskus Instructions for Use identified the steps for use which included, "Before you breathe in your dose from the DISKUS, breath out [exhale] as long as you can..." The Spiriva HandiHaler How To Use Your HandiHaler instructions dated 01/14, identified a procedure for use which included, "Breathe out completely. Then, with the HandiHaler in your mouth, breathe in deeply until your lungs are full." During interview on 8/13/15, at 1:26 p.m. the consulting pharmacist (CP) stated staff should be having the residents exhale deeply before using inhaler medications, "To get the full dose." The facility Oral Inhalation Administration policy dated 1/27/15, identified a procedure for use which included, "Instruct the resident to tilt his/her head back slightly, stand or sit up as straight as possible, and breathe out through mouth [prior to administering the medication]."	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		9/22/15

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F 431	Continued From page 12 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure Fentanyl patches [transdermal narcotic patches used for pain] were disposed of in accordance with facility policy to prevent potential diversion which had potential to affect 5 of 5 residents (R56, R76, R286, R203, and R8) who had current orders for a Fentanyl patch. In addition, the facility failed to ensure medications were accurately labeled with current physician orders for 1 of 4 residents (R117) observed receiving medication. Findings include:	F 431	F 431 Drug Records, Labels/Storage and Biologicals 1. Corrective Action: Staff were corrected regarding disposal of Duragesic patches. Staff member corrected to sue the medication only when the order and the prescription match. If discrepancy to report to charge nurse. 2. Corrective action as it applies to Others: A TMA/RN/LPN staff meeting will be held during the week of 9/7/15. Policies	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245210	A. BUILDING _____ B. WING _____	08/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA SHORES	4527 SHORELINE DRIVE SPRING PARK, MN 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
F 431	Continued From page 13 NARCOTIC PATCH DESTRUCTION: A facility supplied Order Listing Report dated 8/13/15, identified R56, R76, R286, R203, and R8 had current physician orders for "FentaNYL Patch[s] [a narcotic used to treat severe pain] ..." During interview on 8/12/15, at 10:20 a.m. licensed practical nurse (LPN)-C stated two nurses should be present for the removal of the Fentanyl patch when removed from a resident, however, she was unaware of what the facility policy was for the actual destruction of the patch, but stated she would dispose of the used patch in a garbage can. During interview on 8/12/15, at 10:21 a.m. registered nurse (RN)-E stated she just changed a narcotic patch for a resident yesterday (8/11/15), and she removed the used patch from the resident, and discarded it in a sharps container on the medication cart. RN-E stated she was new to the facility and was unaware of what the actual facility policy for the destruction of the patches were. During interview on 8/12/15, at 12:56 p.m. trained medication aide (TMA)-A stated when removing Fentanyl patches from residents, she, "Just disposes of it in my glove [in the trash]." TMA-A stated she was unaware of what the facility policy for the destruction of the narcotic patches was. During interview on 8/13/15, at 10:06 a.m. RN-A stated the Fentanyl patches should be removed, folded in half, and flushed down the sewer. RN-A stated the nursing staff are expected to follow the facility policy for the safe destruction of Fentanyl	F 431	reviewed with staff re: proper disposal of medical waste including narcotics will be addressed. TMAs review these procedures at their mandatory yearly Med Competency Class. 5 R's of Medication Administration reviewed to ensure proper dosing of medication. If medication label and MAR do not match, hold medication and report to charge nurse. When a medication has a change, the medication should be identified with a sticker that there is a change in the instruction. 3. Reoccurrence will be prevented by: A medication administration audit will be conducted randomly 2 times weekly of evenings and day shift on each household. These audits will be completed by the Clinical Coordinator of the designee. Duragesic patches will be checked during this audit as well for proper removal and destruction according to policy. 4. The Correction will be monitored by: a. The audits will be given to the Clinical Administrator and Administrator for review. b. Clinical Administrator will report audits to the QA Team. QA will determine frequency of audits. c. The Clinical Administrator will be responsible for compliance. 5. Date of Completion: 9/22/15	

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	245210	A. BUILDING _____ B. WING _____	08/13/2015

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F 431	Continued From page 14 patches. During interview on 8/13/15, at 1:26 p.m. the consulting pharmacist (CP) stated Fentanyl is a "Commonly abused prescription drug," and the nursing staff should be removing the old narcotic patches and flushing them down the sewer as there could, "Potentially still be some medication left in the patch." A facility Fentanyl Patch - Removal and Disposal Of policy dated 1/27/15, instructed, "Flush use [sic] patch down toilet/hopper, witnessed by a second staff member, or according to the facility protocol for destruction of a controlled substance." INCORRECT MEDICATION LABELING: During observation of medication administration on 8/12/15, at 8:19 a.m. TMA-A prepared R117's medications at a mobile cart outside the dining room and provided the following labeled medications for review: "Vitamin C 500 MG TAB ... 1 TABLET ORALLY 2 TIMES DAILY..." TMA-A placed one Vitamin C pill in the cup for administration as directed by the label, and administered it to R117 who was seated at the dining room table. R117's signed physician orders dated 7/10/15, identified a current order for, "Vitamin C Tablet [medication used to promote health] 500 mg [milligrams] Give 2 tablet by mouth two times a day ..." The physician's order identified two tables and not one tablet to be administered, as observed on 8/12/15 at 8:19 a.m. for R117.	F 431		

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F 431	Continued From page 15 During interview on 8/12/15, at 12:56 p.m. TMA-A stated she only gave R117 one Vitamin C tablet this morning during the medication administration. TMA-A reviewed the current physician orders and stated the label on the medication was incorrect, and R117 should have received two Vitamin C tablets during the morning medication administration. TMA-A stated the medication label should have had a sticker placed on it when the order changed to alert staff to refer to the new directions. During interview on 8/13/15, at 1:12 p.m. registered nurse (RN)-A stated R117's medication label should have been modified to alert staff to the change when her orders changed to avoid causing, "Possible harm to the patient," by causing a medication error. During interview on 8/13/15, at 1:26 p.m. the CP stated the medication label should be changed to direct staff to the new physician order when orders are changed to have less potential for medication errors. A facility policy for label change directions was requested but not provided.	F 431		

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	245210	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/17/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA SHORES	**4527 SHORELINE DRIVE SPRING PARK, MN 55384**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Lake Minnetonka Shores, Building 1, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 3-story building was determined to be of Type I (332) construction. Original construction in 1966 with additions in 1974 & 1982. It has a partial basement and is fully fire sprinklered. 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, is attached to the existing nursing home and is fire separated from an attached assisted living facility. The new construction has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, is fully fire sprinkler protected and is monitored for automatic fire department notification. The new construction contains the kitchen, community room and chapel. The facility has a capacity of 145 beds and had a census of 138 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

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	245210	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/17/2015**

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	245210	A. BUILDING **02 - BLDG TWO** B. WING _____	**08/17/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Lake Minnetonka Shores, Building 2, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18, New Health Care. In June of 2011, this 1-story building was constructed and determined to be of Type II (222) construction. It contains a basement, is attached to the existing nursing home and is fire separated from an attached assisted living facility. The new construction has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, is fully fire sprinkler protected and is monitored for automatic fire department notification. The new construction contains the kitchen, community room and chapel. The facility has a capacity of 145 beds and had a census of 138 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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