



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 14, 2025

Administrator
Langton Shores
1900 West County Road D
Roseville, MN 55112

RE: CCN: 245389
Cycle Start Date: November 21, 2024

Dear Administrator:

On December 31, 2024, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

A handwritten signature in black ink, appearing to read 'H. Zahler'.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 9, 2024

Administrator
Langton Shores
1900 West County Road D
Roseville, MN 55112

RE: CCN: 245389
Cycle Start Date: November 21, 2024

Dear Administrator:

On November 21, 2024, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), 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) 241-7797

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by February 21, 2025 (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 May 21, 2025 (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
Orville L. Freeman Building | HRD 3A 3rd Floor
PO Box 64900
625 Robert Street North
St. Paul, MN 55155
Office: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER LANGTON SHORES			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 WEST COUNTY ROAD D ROSEVILLE, MN 55112		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments On 11/18/24 through 11/21/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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.	E 000			
F 000	INITIAL COMMENTS On 11/18/24 through 11/21/24, a standard recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. 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.	F 000			
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal	F 883			12/19/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/13/2024

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

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F 883	Continued From page 1 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 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;	F 883			

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

PRINTED: 12/31/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245389	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/21/2024
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F 883	Continued From page 2 (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. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure 1 of 5 residents (R1) 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 11/21/2024, identified various tables when each (or all) of the pneumococcal vaccinations should be obtained. This identified when an adult over 50 years old had received the complete series (i.e., PPSV23 and PCV13; see below) then the patient and provider may choose to administer Pneumococcal 20-valent Conjugate Vaccine (PCV20) for patients who had received Pneumococcal 13-valent Conjugate Vaccine (PCV13) at any age and Pneumococcal Polysaccharide Vaccine 23 (PPSV23) at or after 65 years old. R1's quarterly Minimum Data Set (MDS) dated	F 883	It was determined that R1 was eligible to receive the PCV20 vaccination. R1's Responsible Party was contacted on 11/21/24 and consent to administer the vaccine was obtained. The PCV20 vaccination was administered on 11/25/24. Resident did not experience any pneumonia infections since her admission on 2/14/24. All residents who are eligible to receive vaccination are at risk of potentially missing influenza or pneumococcal immunizations under this citation. Full facility audit was completed by the Infection Prevention (IP) RN on 11/21/24 and no other residents were identified as missing immunizations. Admitting Nurse offers the Pneumococcal Vaccine and seasonal Influenza and seasonal COVID vaccines upon admission. Influenza and COVID vaccines may be administered the day of admission if resident in agreement or as soon as possible after admission. Pneumococcal		

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F 883	Continued From page 3 8/19/24, indicated R1 was 95 years old, admitted on 2/24/24, moderately cognitively impaired and has the following diagnoses: anemia (low red blood cells and hemoglobin levels in the blood), hypertension (high blood pressure), hyperlipidemia (high levels of fat in the blood), Alzheimer's disease, dementia, and anxiety. R1's Order summary report dated 11/21/24, indicated on 2/13/24 the provider gave the following two orders: 1) May receive pneumococcal vaccinations if not already received. 2) May receive pneumovax if not already received. R1's Minnesota Immunization Information Connection (MIIC) vaccination record dated 11/19/24, indicated R1 received the pneumococcal polysaccharide PPSV23 on 11/1/1994. In accordance with the CDC recommendations R1 was eligible for a dose any of the following pneumococcal conjugate vaccines: PCV15, PCV20, or PCV21. R1's Point Click Care Immunizations form dated 11/21/24, indicated R1's had refused the vaccination, however there was no evidence of this refusal in R1's medical record. R1's Pneumococcal vaccinations consent form dated 2/14/24, indicated R1's daughter had asked the facility to check R1's records to verify if R1 had received the vaccination or not and did not refuse it. R1's medical record lacked any evidence of follow up regarding the consent form, communication with the family, verification of that data, or any documentation it was administered.	F 883	Vaccine consents are routed to the IP RN to obtain a signed MD/NP. The vaccination is administered once the order is obtained and the vaccine is received from the pharmacy. Weekly immunization audits are completed for the previous week's new admissions by the IP RN. Any concerns identified are followed up on by the IP RN and if unable to contact the Responsible Party when required, and the IP nurse will not be back until the following week, an email will be sent to the Clinical Coordinator and copy to the Clinical Administrator to follow up and ensure the immunization is offered, Responsible Party's decision documented and vaccine is administered if consent obtained. No concerns have been identified on the weekly audits since 11/21/24. Clinical Administrator will review weekly audits and report to QAPI quarterly.		

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F 883	Continued From page 4 On 11/21/24 at 08:59 a.m., the Infection preventionist/registered nurse (RN)-A, stated upon admission the facility would offer influenza, COVID-19, and pneumococcal vaccinations to eligible residents. The vaccination consent order would be sent to the provider to be signed, and then administered after receiving order and vaccination, then documented in the chart. RN-A confirmed R1's consent stated the family member wanted R1's record reviewed, and RN-A confirmed R1's record was never verified, nor the family followed up with. On 11/21/24 at 11:09 a.m., the director of nursing (DON) expected if a resident was eligible for any of the offered vaccinations, those would be provided as soon as the facility was able to. The DON confirmed no follow up was conducted regarding R1. The DON stated there had been a different DON and infection preventionist at the time, and the vaccination had been missed. The DON stated the importance of providing vaccinations to the residents to keep infection rates down, and to prevent the spread of infection within the resident population. On 11/21/24 at 1:11 p.m., R1's family member confirmed the facility had not followed-up regarding vaccinations until today (11/21/24), when they had called to offer it. R1's family member stated they would normally prefer to keep R1's vaccinations up to date. On 11/21/24 at 1:17 p.m., RN-A stated if a resident were to refuse a vaccination at the time of admission, they would go back and offer them again upon discharge, however, RN-A had not been offering them again for long term residents,	F 883			

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F 883	Continued From page 5 such as R1. The Pneumococcal Vaccination Policy last modified July of 2023, indicated all residents who have never received a pneumococcal conjugate vaccine will be offered the vaccine upon admission and as needed in accordance with current CDC recommendations.	F 883			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245389	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - NEW B. WING _____		(X3) DATE SURVEY COMPLETED 11/19/2024
NAME OF PROVIDER OR SUPPLIER LANGTON SHORES			STREET ADDRESS, CITY, STATE, ZIP CODE 1900 WEST COUNTY ROAD D ROSEVILLE, MN 55112		
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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on November 19, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Langton 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	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed

TITLE

(X6) DATE

12/13/2024

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

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K 000	Continued From page 1 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Building Info: Langton Shores is a 3-story building type II (111) and was constructed in 2019. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire	K 000			

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K 000	Continued From page 2 department notification. The facility has a capacity of 50 beds and had a census of 47 at the time of the survey.	K 000			
K 355 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain fire extinguishers per NFPA 101 (2012 edition), Life Safety Code, sections 18.3.5.12 and NFPA 10. This deficient finding could have a isolated on the residents within the facility. Findings include: On 11/19/2024 between 10:00 AM and 11:30 AM, it was revealed by observation that the "K" fire extinguisher in the Kitchen Room was observed blocked by a cart in the kitchen. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	To comply with the safety and security measures to maintain fire extinguishers in accordance with NFPA 101 (12), Life Safety Code sections 18.3.5.12 and NFPA 10, The facility will educate staff to not block the fire extinguisher in the kitchen. A recurring weekly task will be added to the Electronic Work Order System to ensure the fire extinguishers are accessible and not blocked. This will occur starting 12/13/2024 for four weeks, and then a recurring monthly task will be added to the Electronic Work Order System to ensure compliance. Signage has been posted by the fire extinguishers in the kitchen stating to not block the fire extinguishers. The Environmental Services Director will be responsible for ensuring this task is completed as schedule beginning on December 13th, 2024, and report to QAPI	12/19/24	

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K 355	Continued From page 3	K 355	quarterly.		