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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GWJG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00234

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245606**
2.STATE VENDOR OR MEDICAID NO.
(L2) **519842900**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE MINNETONKA CARE CENTER**
(L4) **20395 SUMMERVILLE ROAD**
(L5) **DEEPHAVEN, MN** (L6) **55331**

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)

6. DATE OF SURVEY **08/12/2015** (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 **21** (L18)

13.Total Certified Beds **21** (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: * Code: **A, 8** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	21			
(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):
See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jane Teipel, HFE NEII 08/21/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 08/21/2015 (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 **07/02/1992** (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.
03001 (L31)

30. REMARKS
Posted 09/22/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
07/28/2015 (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5606

On August 12, 2015 a Post Certification Revisit (PCR) was completed to verify the facility achieved substantial compliance with deficiencies issued pursuant to the standard survey completed May 14, 2015 and the Health Comparative Federal Monitoring Survey (FMS) completed on June 5, 2015. We presumed based on the facility's plan of correction that the facility had corrected the deficiencies as of July 30, 2105. Based on our PCR we have determined the facility has corrected the deficiencies issued pursuant to the standard survey completed on May 14, 2015 and the FMS completed on June 5, 2015, effective August 12, 2015.

The facility is again, requesting a waiver of the following health deficiency requirements:

- F458, Bedrooms Measure At least 80 Sq. Ft/ Resident.

In addition, a PCR was completed on July 28, 2015 for the life safety code component of the certification and found corrected as of July 15, 2015. The life safety code was processed under a separate enforcement cycle. The deficiencies cited at K0012 and K0039 have been determined compliant as a result of the FSES.

Refer to the CMS-2567b for for both health and FMS for the results of this visit.

Effective August 12, 2015, the facility is certified for 21 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24 5606

August 21, 2015

Mr. Jeff Sprinkel, Administrator
Lake Minnetonka Care Center
20395 Summerville Road
Deephaven, Minnesota 55331

Dear Mr. Sprinkel:

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 August 12, 2015 the above facility is certified for:

21 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 21 skilled nursing facility beds.

Your request for waiver of F458 has been approved based on the submitted documentation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

July 28, 2015

Mr. Jeff Sprinkel, Administrator
Lake Minnetonka Care Center
20395 Summerville Road
Deephaven, Minnesota 55331

RE: Project Number F5606023

Dear Mr. Sprinkel:

On June 8, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by the Department of Public Safety for a standard survey, completed on June 4, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 28, 2015, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 4, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 30, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 4, 2015, effective June 30, 2015 and therefore remedies outlined in our letter to you dated June 8, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

August 21, 2015

Mr. Jeff Sprinkel, Administrator
Lake Minnetonka Care Center
20395 Summerville Road
Deephaven, Minnesota 55331

RE: Project Number S5606024, S5606025

Dear Mr. Sprinkel:

On June 3, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 14, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On June 5, 2015, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The FMS found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On June 18, 2015, CMS forwarded the results of the FMS and notified you that your facility was not in substantial compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 14, 2015 (42 CFR 488.417(b)).

Also, the CMS Region V Office notified you in their letter of June 18, 2015, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 14, 2015.

On August 12, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey completed on May 14, 2015 and a Federal Monitoring Survey (FMS) completed on June 5, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 30, 2015. Based on our visit, we have determined

that your facility has obtained substantial compliance with the deficiencies issued pursuant to our standard survey completed on May 14, 2015 and the FMS completed on June 5, 2015, effective August 12, 2015.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedy outlined in the CMS letter of June 18, 2015. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 14, 2015, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective August 14, 2015, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 14, 2015, is to be rescinded.

In the CMS letter of June 18, 2015, CMS advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 14, 2015, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 30, 2015, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Your request for a continuing waiver involving the health deficiency cited under F458 at the time of the May 14, 2015 standard and June 5, 2015 Federal Monitoring Survey survey has been approved.

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.

Enclosed is a copy of the Post Certification Revisit Forms, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure(s)

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245606	A. Building B. Wing	8/12/2015

Name of Facility	Street Address, City, State, Zip Code
LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

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 **F0242** Reg. # **483.15(b)** LSC	Correction Completed **06/15/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **06/23/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/23/2015**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **06/23/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/23/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/23/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/15/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix **F0501** Reg. # **483.75(i)** LSC	Correction Completed **06/18/2015**
ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **06/15/2015**	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

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/mm	08/21/2015	33937	08/12/2015
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
5/14/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245606	A. Building B. Wing **01 - MAIN BUILDING**	7/28/2015

Name of Facility	Street Address, City, State, Zip Code
LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

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 Reg. # **NFPA 101** LSC K0012	Correction Completed **07/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0039	Correction Completed **06/30/2015**	ID Prefix Reg. # **NFPA 101** LSC K0045	Correction Completed **06/30/2015**
ID Prefix Reg. # **NFPA 101** LSC K0062	Correction Completed **06/30/2015**	ID Prefix Reg. # **NFPA 101** LSC K0076	Correction Completed **06/15/2015**	ID Prefix Reg. # **NFPA 101** LSC K0147	Correction Completed **06/15/2015**
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 State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
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
6/4/2015				

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

August 21, 2015

Mr. Jeff Sprinkel, Administrator
Lake Minnetonka Care Center
20395 Summerville Road
Deephaven, Minnesota 55331

Re: Enclosed Reinspection Results - Project Number S5606024

Dear Mr. Sprinkel:

On August 12, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 14, 2015, with orders received by you on June 5, 2015. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00234	A. Building B. Wing	8/12/2015

Name of Facility	Street Address, City, State, Zip Code
LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **20255** Reg. # **MN Rule 4658.0070** LSC	**06/15/2015**	ID Prefix **20295** Reg. # **MN Rule 4658.0100 Subp. 4** LSC	**08/12/2015**	ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 2** LSC	**06/23/2015**
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	**06/23/2015**	ID Prefix **20895** Reg. # **MN Rule 4658.0525 Subp. 2.B** LSC	**06/23/2015**	ID Prefix **21220** Reg. # **MN Rule 4658.0700 Subp. 1** LSC	**06/18/2015**
ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 3** LSC	**08/12/2015**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	**06/23/2015**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1 ABC** LSC	**06/23/2015**
ID Prefix **21610** Reg. # **MN Rule 4658.1340 Subp. 1** LSC	**08/12/2015**	ID Prefix **21942** Reg. # **MN St. Statute 144A.10 Subd. 8** LSC	**05/15/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/mm	08/21/2015	33937	08/12/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/14/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245606	LAKE MINNETONKA CARE CENTER

Type of Survey (select all that apply):

D					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 33937	08-11-2015	08-12-2015	2.00	0.00	8.25	0.00	2.00	3.50
2. 30923	08-11-2015	08-12-2015	0.00	0.00	5.00	0.00	0.00	0.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 1.00

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245606	LAKE MINNETONKA CARE CENTER

Type of Survey (select all that apply):

D					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 28120	07/28/2015	07/28/2015	0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.00

Total Clerical/Data Entry Hours.....

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: GWJG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00234

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245606**
2.STATE VENDOR OR MEDICAID NO.
(L2) **519842900**

3. NAME AND ADDRESS OF FACILITY
(L3) **LAKE MINNETONKA CARE CENTER**
(L4) **20395 SUMMERVILLE ROAD**
(L5) **DEEPHAVEN, MN** (L6) **55331**

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)

6. DATE OF SURVEY **05/14/2015** (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 **21** (L18)

13.Total Certified Beds **21** (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, 9** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	21			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Elizabeth Nelson, HFE NEII 07/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 07/28/2015 (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
07/02/1992
(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.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5606

At the time of the May 14, 2015 standard survey the facility was not in substantial compliance with Federal participation requirements. The facility has been given an opportunity to correct before remedies would be imposed. The most serious deficiency is a widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F)

The facility is again, requesting a waiver of the following health deficiency requirement:

- F458, Bedrooms Measure At least 80 Sq. Ft/ Resident.

In addition, the life safety code deficiencies cited at K0012 and K0039 have been determined compliant as a result of the FSES.

Refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction, CMS 2786T (FSES report) and letter of request for the Health waiver (F458). Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0358

June 3, 2015

Mr. Jeff Sprinkel, Administrator
Lake Minnetonka Care Center
20395 Summerville Road
Deephaven, Minnesota 55331

RE: Project Number S5606024

Dear Mr. Sprinkel:

Please note: Health and Life Safety Code (LSC) surveys will be processed under separate enforcement cycles. Findings for the LSC survey will follow when complete.

On May 14, 2015, a standard survey was completed at your facility by the Minnesota Department of Health 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567

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>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;

Potential Consequences - 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:

Gayle Lantto, Unit Supervisor
Metro D Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite #220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gayle.lantto@state.mn.us

Phone: (651) 201-3794
Fax: (651) 215-9697

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 June 23, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 23, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 August 14, 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 November 14, 2015 (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 a PoC 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

(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. 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 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	**F-242** **6-15-15** R1 will be offered a shower 3 days a week. R 22 will be offered a shower daily. Every current resident will be interviewed in order to determine their weekly bathing preferences. Additionally, all new residents will be asked their bathing preferences upon admission. All residents will be asked, upon completion of their Annual MDS, if their bathing preferences are being met to their satisfaction. The DON will be responsible for the implementation and monitoring of resident bathing preferences.	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a system for ongoing identification of resident needs and preferences related to bathing for 2 of 3 residents (R1, R22) reviewed for choices. Findings include: R1 stated in an interview on 5/12/15, at 9:00 a.m. although he had a shower two days a week, his preference would have been to shower three days a week. The resident had not informed the	F 242	GL/mm 06/19/15	

RECEIVED
JUN 17 2015
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 6-15-15

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 242	Continued From page 1 staff, nor had he been asked by staff if bathing twice a week was okay with him. R1's quarterly Minimum Data Set (MDS) dated 3/16/15, identified R1 was independent in bed mobility, transferring, walking and personal hygiene/bathing with set up only. Review of the bath schedule indicated R1 was scheduled for a shower two days a week. R1's care plan revised on 12/28/13, identified an ADL self-care performance deficit related to cognitive loss/poor decision-making. Interventions for bathing and showering indicated resident was able to shower independently, but was supervised for completion, thoroughness and safety. R22 stated in an interview on 5/12/15, at 8:38 a.m. although she had a shower two days a week, her preference would have been to shower every day of the week. The resident had not informed the staff, nor had she been asked by staff if bathing twice a week was acceptable in her opinion. R22 had been recently admitted to the facility. A review of the bath schedule indicated R22 was scheduled for a shower two days a week. R22's temporary care plan dated 5/11/15, identified limited physical mobility related to weakness/pain. During an interview on 5/14/15, at 5:50 p.m. the director of nursing (DON) stated R1 was "pretty independent" in bathing so it would not have been a problem if he wanted more than two baths a week. The DON further indicated she was unaware R1 or R22 wanted additional baths, and said the facility did not have a process either upon admission or ongoing to determine a resident's bathing frequency preferences.	F 242		

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F 242	Continued From page 2 A policy was requested but not provided.	F 242	**F-279** **7-3-15**	
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop care plan goals and interventions to address the use of high risk medications for 2 of 5 residents (R7, R4) reviewed for unnecessary medications; for range of motion for 1 of 1 resident (R4) reviewed for range of motion; and to honor medication preference for 1 of 2 residents (R1) reviewed for dignity.	F 279	R7 will have their care plan revised to include: the identification of any risk of constipation, medication uses and their possible side effects, and any risks for hypo/hyperglycemia. A toileting plan will also be developed for this resident. R4 will have their care plan revised to address her limited ROM and to minimize further possible contractures. R1 will have their care plan revised to reflect the resident's refusal to take both medications on the day shift and/or from specific nurses working other shifts. The plan will include the setting up of the mediations for him to take at appropriate times. All resident care plans will be revised to include specific preferences and goals. Upon admission a temporary care plan will be initiated and a permanent care plan completed within 1 month of admission. Further, a policy will be developed	

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F 279	Continued From page 3 Findings include: R7's care plan revised 11/29/13, did include the development of goals and interventions related to the use of high risk medications including laxatives, insulin, and those with known anticholinergic (drying) side effects. R7's current physician orders dated 4/10/15, revealed an order for the following medications which are known to have an anticholinergic effect (a class of drugs that block the action of the neurotransmitter acetylcholine in the brain and help to block involuntary movements of the muscles associated with certain diseases): 1) Artane (trihexyphen) 5 milligrams (mg) daily for extrapyramidyl side effects (EPSE); 2) Ditropan (oxybutynin) 5 mg twice daily for urinary incontinence; and 3) Symetrel (amantiadine) 100 mg every day for EPSE. The potential significant side effects of anticholinergic's included: dry mouth, blurred vision, constipation, drowsiness, sedation, hallucinations, memory impairment, difficulty urinating, confusion, delirium , decreased sweating and saliva, causing increased risk for falls and constipation. However, R7's care plan revised on 11/29/13, failed to identify use and risk of anticholinergic medication use, and monitoring interventions. R7 was also prescribed the following medications for constipation; Senna Lax 8.6 mg twice daily and Miralax one capful with juice or water everyday. The care plan revised on 11/29/13, failed to identify R7's risk for constipation, medication use, monitoring and potential interventions to decrease use for medication, such as increasing water, dietary adjustments, exercise.	F 279	in which all care plans will be monitored monthly to ensure that they are kept current. The DON will be responsible for monitoring the schedule and reviewing for compliance with the care plan policy.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 4 R7 was also prescribed the following insulin for insulin dependent diabetes mellitus: Novolog (fast acting insulin) three time daily and per sliding scale based on blood glucose level and Lantus (long acting insulin) at bedtime. The care plan revised 11/29/13, identified R7 was prescribed a therapeutic low concentrated sugar and low potassium diet, however, the care plan revised on 11/29/13, did not identify the R7's risk for hypoglycemic and hyperglycemic incidents related to use of insulin and goal for glucose control. R7 was also prescribed oxybutynin (Ditropan) 5 mg twice daily for urinary incontinence. The care plan revised on 11/29/13, indicated the resident had bladder incontinence related to improper toileting habits, however, a plan was lacking for the monitoring of efficacy of drug or potential tapering or discontinuation of the medication. R7's quarterly Minimum Data Set (MDS) dated 2/11/15, indicated R7 was occasionally incontinent of urine (less than seven times a week) and had no toileting plan. R4's care plan did not address resident's limitations in range of motion and plan to maintain or minimize the risk for further decline. R4 was observed on 5/12/15, at 3:14 p.m. to have contractures of both hands and knees without splint devices and/or braces. The following day R4 was observed at breakfast at 7:45 a.m. while totally assisted with breakfast by a nursing assistant (NA)-A. R4's care plan dated 11/3/12, identified a ADL (activities of daily living) functional problem	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 5 related to transfers and locomotion (non-weight bearing) and total dependence on staff for performance. The interventions directed staff to use the mechanical lift for all transfers to/from bed to wheelchair and to propel resident in wheelchair to/from room to day room, deck, transportation vehicle. The care plan also identified a ADL functional problem related to dressing and personal hygiene related to total dependence on staff for performance. The care plan interventions under the area of eating/nutrition revised 11/1/13, directed staff to set up and serve all meals and staff to feed resident and provide 1:1 supervision for swallowing /choking. The care plan did not address R4's limitation in range of motion and plan to maintain or prevent further decline in range of motion. In an interview with the DON on 5/14/15, at 3:28 p.m. stated no ROM was currently being provided to R4, and the care plan did not include R4's limitation in ROM or plan to maintain or prevent further decline in range of motion. R4's care plan also did not address insomnia and non-pharmacological interventions to promote sleep and use of medication to prevention urinary tract infections. R4's current physician orders dated 4/6/15, included an order for Trazodone (antidepressant commonly prescribed for insomnia) 50 mg at bedtime. The medication was prescribed for insomnia, and was initiated prior to 6/4/14. R4's care plan revised 11/1/13, identified psychotropic drug however did not address insomnia, use of medication and non-pharmacological interventions to promote sleep.	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 6 In an interview with DON on 5/14/15, at 3:04 p.m. acknowledged the care plan did not include the use of the Trazodone, nor non-pharmacological interventions to promote sleep. R4's current physician orders dated 4/6/15, included an order for cephalexin (antibiotic) cap 250 mg take one four times a day for the 1st three days of the months for urinary tract infection (UTI) prevention which was started on 9/17/14. R4's care plan revised 11/3/13, identified a ADL (activities of daily living) functional problem related to toileting/risk of urinary incontinence to total dependence on staff for performance. The care plan did not direct staff to monitor for UTIs, nor was the use of prophylactic antibiotic included in the resident's care plan. In a follow up interview with DON on 5/14/15, at 4:58 p.m. she indicated R4 had a history of urinary tract infections, with the last infection in 5/14, and prior to that in 10/13. The DON indicated the medication was reduced from being administered for the first 10 days of the month to the first three days of the month on 6/13. The DON acknowledged the care plan did not include the use of the cephalexin. R1's care plan did not address resident's preferences related to medication delivery. On 5/12/15 at 9:01 a.m. during an interview with R1, resident stated that a staff person (licensed practical nurse or LPN-A) administered medication to him that "messes up" his stomach. R1 further indicated the nurse that the that worked during the day "does not give medication that messes up" his stomach.	F 279		

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F 279	Continued From page 7 R1's quarterly MDS dated 3/16/15, indicated R1 was cognitively impaired and identified a diagnosis of schizophrenia. R1's integrated progress notes revealed the following: 1) On 10/9/14 Informed by night nurse that NA had found resident's medication in the garbage in the day room...Informed him they were found in the garbage and did he know how they got there 'no I don't'...res [resident] kept coming coming back every few minutes stating those pills hurt my stomach." 2) On 10/22/14 the ombudsman called reporting he had received several calls from the resident regarding stomach problems that were not new to him. The ombudsman was informed the resident had been non-compliant with taking his medications, and had seen the physician twice that month. 3) On 10/28/14 "Ombudsman here...told him would not take meds from evening/noc [night] nurses, he feels that they are putting poison on his meds and it hurts his stomach...ingested ben gay [topical pain medication] earlier this year. Resident again stated that he would not accept meds from anyone working evening, noc shift but would accept from nurses that work during day. Call placed to [physician]. 5) On 10/30/14 Call to psychologist to inform of not taking meds from pm/eve [evening] nurse." R1's care plan revised 12/28/13, identified resident as having impaired cognitive function/dementia or impaired thought process related to impaired decision making secondary to long standing mental illness (paranoid schizophrenia). Interventions directed staff to administer medication as ordered. The plan, however, did not include the need to schedule medications as possible during the day shift to	F 279		

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F 279	Continued From page 8 promote R1's compliance with taking medications. In an interview with the DON, on 5/14/15, at 4:53 p.m. she explained she had been at the facility fewer than six months, but was aware resident care plans "are a problem." The DON explained she was prioritizing work and although she had planned to review all the resident care plans, had not found the time to do so.	F 279	**F-282** **7-3-15** A current DISCUS will be conducted for R4. A Policy and schedule will be developed for maintaining a current DISCUS for residents in need of them. Current DISCUS evaluations will be checked with each MDS due for a resident. R4 will have their care plan revised to indentify what psychotropic drug side effects to monitor for and report these to the resident's physician. R10 will have their care plan revised to identify what side effects the resident should be monitored for. A schedule for conducting Orthostatic blood pressure tests on residents has already been developed and is in effect. A policy for Orthostatic blood pressures will be written. The DON will be responsible for overseeing the completion of the DISCUS evaluations on the residents and that the schedule is adhered to.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for monitoring for potential side effect of antipsychotic medication for 2 of 5 (R4, R10) residents reviewed for unnecessary medications. Findings include: R4's current physician orders revealed an order dated 3/17/15, for haloperidol 0.5 mg twice daily for paranoid psychosis, which was increased to 1 mg twice daily on 4/7/15. The care plan dated 11/3/12, identified R4 as fall risk related to psychotropic medications. The interventions directed staff to observe for psychotropic drug side effects and report to physician, psychiatrist review every 30 days for efficacy and side effects and	F 282		

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F 282	Continued From page 9 primary medical physician every 60 days or PRN (as needed) for efficacy and side effects and pharmacist review of psychotropic medications every month. R4's record revealed DISCUS was dated as being completed on 12/29/07. No further TD assessments were found in the record. In an interview with the DON on 5/14/15, at 3:04 p.m. indicated she was unable to find any DISCUS assessment since 12/29/07 for R4. R10's current physician orders signed 4/2/15, revealed an order for Invega (antipsychotic medication) 9 mg daily for obsessive compulsive disorder and bipolar disorder, started on 1/8/14. The care plan identified R10 as utilizing psychotropic medications (Invega, divalproex) related to bipolar disorder. The interventions directed staff to administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness every shift, monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, extrapyramidyl side effects (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person, pharmacist to review psychotropic medications monthly for efficacy, dosage and side effects, primary physician to evaluate all medication, including psychotropics meds [medications] every 60 days or PRN for efficacy, dosage, and side effects, psychiatrist to evaluate psychotropic drug medications monthly or PRN for efficacy, dosage and side effects.	F 282		

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F 282	Continued From page 10 R10's record lacked evidence of orthostatic blood pressure monitoring related to antipsychotic medication use. Review of the record revealed no orthostatic blood pressure monitoring completed in last 11 months. R10's record revealed a DISCUS was not completed. In an interview with the DON on 5/14/15, at 4:46 p.m. stated she was unable to find any documentation in the record to indicate orthostatic blood pressures or assessment for TD side effects was done. The DON further stated she would call the attending psychiatrist to see if an assessment was done recently by psychiatrist. When questioned regarding how often a resident is assessed for TD, the DON stated "I would have to check our policy, but would guess once a year." No further information was provided, including a related policy.	F 282	**F-318** **7-3-15** An Occupational Therapy consult has been ordered for R4 to develop a ROM plan for the resident to reduce their risk for worsening of contractures. Any Resident noted to have a decrease in ADL capabilities during the completion of their MDS will be assessed for the need for ROM effective immediately. A policy will be developed to identify those resident's who have the potential to develop contractures. Any new or worsening of contractures will be noted in the Quarterly QA meetings. The DON will be responsible for developing and implementing the policy and ensuring that ROM for all residents is assessed timely.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nursing rehabilitative services to maintain or improve range of motion (ROM) for 1 of 1 resident (R4)	F 318		

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F 318	Continued From page 11 reviewed for ROM. Findings include: R4 was observed on 5/12/15, at 3:14 p.m. to have contractures of both hands and knees without splint devices and/or braces. The following day R4 was observed at breakfast at 7:45 a.m. while totally assisted with breakfast by a nursing assistant (NA)-A. During the afternoon of 5/13/15, at 1:12 p.m. NA-A transferred R4 from her wheelchair to bed using a mechanical lift. NA-A then assisted R4 in turning from side side to remove the mechanical lift transfer sheet. NA-A was interviewed on 5/13/15, at 1:14 p.m. and said she did not provide any range of motion exercises to R4. NA-A further explained she had not been instructed to complete ROM exercises for R4 and further stated R4 did not utilize any braces or splints. In an interview with the director of nursing (DON) on 5/11/15, at 5:22 p.m. she stated R4 had contractures of both knees, hands and hips. The DON further stated R4 had "refused" ROM exercises in the past. R4's quarterly Minimum Data Set (MDS) dated 4/28/15, included diagnoses of dementia and hemiplegia (paralysis of one side of the body). The MDS indicated R4 had cognitive impairment, was unable to walk, required extensive assistance with activities of daily living (ADLs), and had a ROM impairment on both sides of upper and lower extremities. The MDS also indicated R4 was not receiving restorative nursing, physical or occupational therapy. The care area assessment (CAA) dated 10/26/14,	F 318		

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F 318	Continued From page 12 indicated "Resident has contracture's of her arms, wrists, fingers and legs ... Resident requires extensive assist with bed mobility and total assist with transfers, locomotion on/off the unit, dressing, eating, toileting, grooming and bathing." R4's care plan reviewed 11/3/12, indicated R4 was totally dependent on staff in ADLs. The intervention directed staff to use mechanical lift for all transfers and to propel wheelchair to and from destinations. In a follow up interview with the DON on 5/14/15, at 3:28 p.m. stated she had a previous conversation with R4's family in 3/15 or 4/15, and they indicated if the DON could "talk mom into it," they would pay for occupational or physical therapy evaluation. Although the DON had attempted to approach the resident about it, she had refused, but stated, "I should talk to her again." DON reviewed R4's chart and was unable to find any documentation of conversation with R4 or her family. The DON further indicated no ROM was currently being provided to R4. A policy was requested but not provided.	F 318	**F329** **7-30-15** The skilled, psychiatric care focus of the staff at the facility helps to monitor the side effects of antipsychotic medications, working closely with the residents and their outside care providers to minimize these effects. To ensure that a resident does not receive any unnecessary medication without proper monitoring, indication, dosage or duration and in the presence of adverse events, the consultant pharmacist will review the medications of each resident on a monthly basis. The consultant pharmacist will make recommendations and request documentation of facility staff and prescribers in order to ensure that proper documentation for the resident's need for the medication is obtained and to start antipsychotic medication therapy and/or requests for gradual dosage reductions of these medications, unless clinically contraindicated. For residents R4, R7, R9 and R10 (and all residents in need) a written	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any	F 329		

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F 329	Continued From page 13 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor for potential side effect of antipsychotic medication and/or to ensure efficacy of sleep medication was documented for 4 of 5 (R9, R7, R4, R10) residents reviewed for unnecessary medications. Findings include: R9 was prescribed the antipsychotic, clozapine 50 mg daily since 8/4/14. R9's record, however, lacked evidence of monitoring in the previous nine months for the potential for orthostatic blood pressure monitoring (a sudden drop in blood pressure with position change, such as standing or sitting up from a lying position) related to antipsychotic use. The annual Minimum Data Set (MDS) dated 3/15/15, revealed the resident ambulated independently and had experienced	F 329	form requesting documentation regarding an attempt to reduce the dosages of the antipsychotic medications or rationale as to why a reduction would be detrimental to the care will be written and left at the facility for the prescribers to view and complete. This will be done with the next consultant pharmacist review during the month of June 2015. The pharmacy consultant will follow up with any prescriber who does not complete the form. A request will be made for each resident's prescriber to evaluate for possible side effects of the prescribed antipsychotic medications (specifically R7 & R9 & R10's prescribers will be requested to report on the potential causal incidents of orthostatic blood pressure due to the antipsychotic medications prescribed for their patient. R7's prescriber will be asked to clarify the correct incidents when use of an "as needed" antipsychotic medication is therefore warranted, i.e. target behaviors, R4's prescriber will be	

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F 329	Continued From page 14 two falls since the previous assessment period. R7 was prescribed the antipsychotic Seroquel as needed (PRN), however, specific target behaviors were not identified and potential side effects including orthostatic hypotension and tardive dyskinesia (or TD--neurological syndrome characterized by repetitive, involuntary movement long-term use of certain drugs, including antipsychotics). On 5/13/15, at 7:55 a.m. R7 was observed sitting at nursing station administering her insulin with supervision. Later in the afternoon, at 2:25 p.m. R7 was assisted by a nursing assistant (NA)-B ambulating with a walker in the hallway. R7's current physician orders dated 4/10/15, revealed an order for Seroquel 50 milligrams (mg) as needed every four hours for agitation. The medication was ordered on 12/12/14, by the attending psychiatrist. The Medication Administration Record (MAR) indicated R7 was administered Seroquel as follows during the previous four months: 1) In 1/15-- administered seven times for c/o anxiety five times, complaints of aviation one time and per resident request one time 2) In 2/15-- administered three times "res c/o anxiety, restlessness, sadness" and "outbursts/anxiety/crying." 3) In 3/15--administered one times for "yelling, screaming and swearing." 4) In 4/15--administered three times for "anxiety" as documented two of three times administered. R7's quarterly MDS dated 2/11/15, indicated the resident was cognitively intact, and was	F 329	asked to clarify & justify the need and be requested to have a trial dosage reduction attempt for the currently used sleep aid. This will be done at the monthly consultant pharmacist review during the month of June 2015. While the facility has engaged a consultant in the past, the facility will engage the services of someone to conduct the Tardive Dyskinesia monitoring (DISCUS evaluations). That individual will be responsible for completing these evaluations. The DON will be responsible for monitoring the implementation of these protocol.	

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F 329	Continued From page 15 independent in bed mobility, transferring and walking in room, and with supervision outside of the room. Diagnoses on the MDS included hypertension, diabetes, schizophrenia, anxiety, depression and Parkinson's disease. The MDS indicated R7 showed minimal signs of depression and exhibited no behavioral problems. R7 had taken antidepressant and antipsychotic medication daily for the last seven days of the assessment period. The care plan dated 11/29/13, identified R7 as having potential the potential to be verbally aggressive (yelling, excessive profanity, slamming doors) related to mental, emotional illness, ineffective coping skills, having poor impulse control most commonly in response to redirections/correction or if she felt she was not getting enough attention from others. The goal statement was, "resident will have no more than 1 angry outburst per week." Interventions directed staff to administer medications as ordered, monitor/document for side effects and effectiveness. The care plan also identified R7 as utilizing psychotropic medications (clozapine, Cymbalta, divalproex ER, and Seroquel as needed) related to schizoaffective disorder, depression and anxiety. The interventions directed staff to administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness every shift, consult with pharmacy and psychiatrist every 30 days and primary medical physician every 60 days for efficacy, side effects, and dosage reduction if applicable, educate the resident/caregivers about risks, benefits and the side effects and/or toxic symptoms of psychotropic medication, monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady	F 329		

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F 329	Continued From page 16 gait, tardive dyskinesia, extrapyramidyl side effects (shuffling gait, rigid muscles, shaking). R7's record revealed no evidence of orthostatic blood pressure monitoring having been completed in the previous 11 months. Fall Tracking Forms (incident reports) revealed R7 experienced the following falls in the last five months: 1) On 1/11/15, at 7:00 a.m. walking independently without use of walker, shoes and socks; 2) On 1/18/15, at 7:45 a.m. fell while ambulating independently but unwitnessed; 3) On 3/14/15, at 8:00 a.m. fell while ambulating independently in dayroom; 4) On 4/11/15, unknown time, fall while walking independently to bed; 5) On 4/17/15, at 7:30 a.m. fell to floor, resident reported she "'fainted"' but fall tracking form indicated "knees buckled." R7's record revealed a Dyskinesia Identification System Condensed User Scale (DISCUS), used to diagnose potential TD, was dated as last having been completed in 6/12. No further TD assessments were found in the record. In addition, R7 was also prescribed oxybutynin (Ditropan) 5 mg twice daily for urinary incontinence, on 4/23/14. Physician progress notes from 6/6/14 to 3/26/15, lacked justification for the continued need of oxybutynin and whether the benefits outweighed potential anticholenergic side effects. R7's quarterly MDS dated 2/11/15, identified R7 as being occasionally incontinent of urine (fewer than seven episodes a week) with no toileting	F 329		

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F 329	Continued From page 17 program. The care plan revised on 11/29/13, indicated the resident had bladder incontinence related to improper toileting habits. The goal stated "The resident will be continent during waking hours. The interventions directed staff to check every two hours during the night and as required for incontinence, wake every two hours at night to void and monitor for signs and symptoms of urinary tract infection. In an interview with the director of nursing (DON) on 5/14/15, at 4:46 p.m. she reported she was unable to find any documentation in R7's record to indicate orthostatic blood pressures or TD assessments had been completed. The DON further stated she would call the attending psychiatrist to see if an assessment had recently been completed in their office. When questioned about frequency of testing for TD for a resident on antipsychotic medication the DON stated, "I would have to check our policy, but would guess once per year." At 4:49 p.m. the DON stated that R7 was previously prescribed Haldol (antipsychotic) PRN, but was since it interfered with another medication, it was discontinued and Seroquel was added. The DON indicated she was unable to locate a related policy, and no further information was provided related to TD assessment. R4's was current physician orders dated 4/6/15, included an order for Trazodone (antidepressant commonly prescribed for insomnia) 50 mg at bedtime. The medication was prescribed for insomnia, and was initiated prior to 6/4/14. R4's medical record lacked evidence of an assessment of sleep patterns, identification of	F 329		

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F 329	Continued From page 18 potential causal factors for sleep disturbance, documentation of non-pharmacological interventions and the effectiveness of interventions tried prior to the initiation of the sleep aid and monitoring of hours of sleep to determine the effectiveness of the the sleep aid medication. In addition, no attempt at a dose reduction for greater than 11 months was attempted. During the morning of 5/13/15, at 7:45 a.m. NA-A was observed providing total assistance to R4 with her breakfast. In the afternoon at 1:12 p.m. NA-A transferred R4 from her wheelchair to bed using a mechanical lift. NA-A then assisted R4 in turning from side side to remove the mechanical lift transfer sheet. R4's physician progress notes, revealed a note on 4/6/15, 2/215, 12/1/14 "Sleeping well." Also on 12/1/14, progress note indicated "Overall feels generally a little more fatigued than in the past." Review of the psychiatrist/physician progress notes revealed no documentation to justify the lack of a dose reduction and continued need of the Trazodone. R4's quarterly MDS dated 1/26/15, identified cognitive impairment and a diagnosis of dementia. The MDS also identified mood symptoms of feeling tired or having little energy, and utilizing a antidepressant medication daily over the last seven days of the assessment period. R4's Night Shift Monthly Charting dated 1/1/15, under the category of Sleep Pattern, had a check mark on "sleeps through" and hand written note	F 329		

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F 329	Continued From page 19 "Trazodone at HS [hours of sleep] for insomnia." In addition, on 12/8/14, it was also noted the resident "sleeps through." R4's care plan dated 11/3/12, identified a mood/behavior problem related to dementia, delusions and being critical of others, but lacked identification of problems with insomnia. R4's integrated progress notes contained no documentation related to monitoring of hours of sleep or non-pharmacological interventions utilized to promote sleep. Upon further review of the record, no documentation of a sleep assessment to identify potential contributing factors and potential non-pharmacological interventions to promote sleep and monitoring of sleep hours to determine efficacy of medication was found. R4's current physician orders also revealed an order dated 3/17/15, for haloperidol 0.5 mg twice daily for paranoid psychosis, which was increased to 1 mg twice daily on 4/7/15. Further review revealed a DISCUS completed 12/29/07. No further TD assessments were found in the record. In an interview with the DON on 5/14/15, at 3:04 p.m. she verified the facility currently had no system for monitoring hours of sleep or a sleep hygiene assessment for residents who utilized medication to promote sleep. The DON explained nursing staff had been completing a monthly flow sheet that contained check boxes related to sleep patterns. The flow sheet had noted 1) sleeps through; 2) awake on and off; and 3) sleep less than four hours. The use of the flow sheet had been discontinued in 1/15. The DON reported she was unable to find any DISCUS assessment	F 329		

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F 329	Continued From page 20 since 12/29/07 for R4. R10 was observed on 5/13/15, at 8:15 a.m. ambulating independently and visiting with other residents sitting in dayroom area. The resident's current physician orders signed 4/2/15, revealed an order for Invega (antipsychotic medication) 9 mg daily for obsessive compulsive disorder and bipolar disorder, started on 1/8/14. R10's quarterly MDS dated 3/29/15, identified the resident had no cognitive impairment and had diagnoses of hypertension, bipolar disease, schizophrenia. The resident had utilized antipsychotic medication daily over the previous seven days during the assessment period. The MDS also identified R10 as being independent in bed mobility, transferring and walking. The record for R10 lacked evidence of orthostatic blood pressure monitoring related to antipsychotic medication use, and no orthostatic blood pressure monitoring had been recorded in the previous 11 months. In addition, a DISCUS had not completed. In an interview with the DON on 5/14/15, at 4:46 p.m. stated she was unable to find any documentation in the record to indicate orthostatic blood pressures or a TD assessment. The DON further stated she would call the attending psychiatrist to see if an assessment was completed recently by psychiatrist. When questioned regarding how often a resident was assessed for TD, the DON stated "I would have to check our policy. No further information was provided. Policies were requested but not provided.	F 329		

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F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consultant pharmacist failed to ensure medication regimens were free from unnecessary medications for 4 of 5 residents (R9, R7, R4, R10) reviewed for unnecessary mediation use. Findings include: R9 was prescribed the antipsychotic, clozapine 50 mg daily since 8/4/14. R9's record, however, lacked evidence of monitoring in the previous nine months for the potential for orthostatic blood pressure monitoring (a sudden drop in blood pressure with position change, such as standing or sitting up from a lying position) related to antipsychotic use. The annual Minimum Data Set (MDS) dated 3/15/15, revealed the resident ambulated independently and had experienced two falls since the previous assessment period. Monthly consultant pharmacist reviews revealed no recommendations of drug irregularities over past 11 months for R9.	F 428	**F428** **7-30-15** The drug regimen review will continue on a monthly basis. Beginning with the June 2015's review requests for gradual dose reductions, requests for clarification on drug/diagnosis rationale and ay reports of potential adverse events caused by a medication therapy will be made available by a form at the facility. Additionally, the phrase, "No other pharmacy concerns" will not be used by the pharmacy consultant in order to minimize any confusion of discounting all previously documented findings. A copy of these recommendations will be left on file in the consultant pharmacist's binder at the facility for review by all care providers for their immediate review. The DON will be responsible for monitoring the implementation of these protocol.	

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F 428	Continued From page 22 R7 was prescribed the antipsychotic Seroquel as needed (PRN), however, specific target behaviors were not identified and potential side effects including orthostatic hypotension and tardive dyskinesia (or TD--neurological syndrome characterized by repetitive, involuntary movement long-term use of certain drugs, including antipsychotics). R7's current physician orders dated 4/10/15, revealed an order for Seroquel 50 milligrams (mg) as needed every four hours for agitation. The medication was ordered on 12/12/14, by the attending psychiatrist. The Medication Administration Record (MAR) indicated R7 was administered Seroquel as follows during the previous four months: 1) In 1/15-- administered seven times for c/o anxiety five times, complaints of aviation one time and per resident request one time 2) In 2/15-- administered three times "res c/o anxiety, restlessness, sadness" and "outbursts/anxiety/crying." 3) In 3/15--administered one times for "yelling, screaming and swearing." 4) In 4/15--administered three times for "anxiety" as documented two of three times administered. R7's record revealed no evidence of orthostatic blood pressure monitoring having been completed in the previous 11 months. Fall Tracking Forms (incident reports) revealed R7 experienced the following falls in the last five months: 1) On 1/11/15, at 7:00 a.m. walking independently without use of walker, shoes and socks;	F 428		

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F 428	Continued From page 23 2) On 1/18/15, at 7:45 a.m. fell while ambulating independently but unwitnessed; 3) On 3/14/15, at 8:00 a.m. fell while ambulating independently in dayroom; 4) On 4/11/15, unknown time, fall while walking independently to bed; 5) On 4/17/15, at 7:30 a.m. fell to floor, resident reported she "'fainted'" but fall tracking form indicated "knees buckled." R7's record revealed a Dyskinesia Identification System Condensed User Scale (DISCUS), used to diagnose potential TD, was dated as last having been completed in 6/12. No further TD assessments were found in the record. In addition, R7 was also prescribed oxybutynin (Ditropan) 5 mg twice daily for urinary incontinence, on 4/23/14. Physician progress notes from 6/6/14 to 3/26/15, lacked justification for the continued need of oxybutynin and whether the benefits outweighed potential anticholenergic side effects. R7's quarterly MDS dated 2/11/15, identified R7 as being occasionally incontinent of urine (fewer than seven episodes a week) with no toileting program. Monthly consultant pharmacist reviews from 6/30/14 to 4/12/15, revealed no recommendations of drug irregularities over past 10 months for R7. In an interview with the director of nursing (DON) on 5/14/15, at 4:46 p.m. she reported she was unable to find any documentation in R7's record to indicate orthostatic blood pressures or TD assessments had been completed. The DON further stated she would call the attending	F 428		

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F 428	Continued From page 24 psychiatrist to see if an assessment had recently been completed in their office. When questioned about frequency of testing for TD for a resident on antipsychotic medication the DON stated, "I would have to check our policy, but would guess once per year." At 4:49 p.m. the DON stated that R7 was previously prescribed Haldol (antipsychotic) PRN, but was since it interfered with another medication, it was discontinued and Seroquel was added. The DON indicated she was unable to locate a related policy, and no further information was provided related to TD assessment. R4's was current physician orders dated 4/6/15, included an order for Trazodone (antidepressant commonly prescribed for insomnia) 50 mg at bedtime. The medication was prescribed for insomnia, and was initiated prior to 6/4/14. R4's medical record lacked evidence of an assessment of sleep patterns, identification of potential causal factors for sleep disturbance, documentation of non-pharmacological interventions and the effectiveness of interventions tried prior to the initiation of the sleep aid and monitoring of hours of sleep to determine the effectiveness of the the sleep aid medication. In addition, no attempt at a dose reduction for greater than 11 months was attempted. R4's physician progress notes, revealed a note on 4/6/15, 2/215, 12/1/14 "Sleeping well." Also on 12/1/14, progress note indicated "Overall feels generally a little more fatigued than in the past." Review of the psychiatrist/physician progress notes revealed no documentation to justify the lack of a dose reduction and continued need of	F 428		

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F 428	Continued From page 25 the Trazodone. R4's Night Shift Monthly Charting dated 1/1/15, under the category of Sleep Pattern, had a check mark on "sleeps through" and hand written note "Trazodone at HS [hours of sleep] for insomnia." In addition, on 12/8/14, it was also noted the resident "sleeps through." R4's integrated progress notes contained no documentation related to monitoring of hours of sleep or non-pharmacological interventions utilized to promote sleep. Upon further review of the record, no documentation of a sleep assessment to identify potential contributing factors and potential non-pharmacological interventions to promote sleep and monitoring of sleep hours to determine efficacy of medication was found. The monthly consultant pharmacist reviews from 6/30/14 to 4/12/15, revealed no recommendations of drug irregularities over past 10 months for R4. R4's current physician orders also revealed an order dated 3/17/15, for haloperidol 0.5 mg twice daily for paranoid psychosis, which was increased to 1 mg twice daily on 4/7/15. Further review revealed a DISCUS completed 12/29/07. No further TD assessments were found in the record. In an interview with the DON on 5/14/15, at 3:04 p.m. she verified the facility currently had no system for monitoring hours of sleep or a sleep hygiene assessment for residents who utilized medication to promote sleep. The DON explained nursing staff had been completing a monthly flow sheet that contained check boxes related to sleep patterns. The flow sheet had noted 1) sleeps	F 428		

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F 428	Continued From page 26 through; 2) awake on and off; and 3) sleep less than four hours. The use of the flow sheet had been discontinued in 1/15. The DON reported she was unable to find any DISCUS assessment since 12/29/07 for R4. R10's current physician orders signed 4/2/15, revealed an order for Invega (antipsychotic medication) 9 mg daily for obsessive compulsive disorder and bipolar disorder, started on 1/8/14. The record for R10 lacked evidence of orthostatic blood pressure monitoring related to antipsychotic medication use, and no orthostatic blood pressure monitoring had been recorded in the previous 11 months. In addition, a DISCUS had not completed. The monthly consultant pharmacist reviews from 6/30/14 to 4/12/15 revealed no recommendations of drug irregularities over past 10 months. In an interview with the DON on 5/14/15, at 4:46 p.m. stated she was unable to find any documentation in the record to indicate orthostatic blood pressures or a TD assessment. The DON further stated she would call the attending psychiatrist to see if an assessment was completed recently by psychiatrist. When questioned regarding how often a resident was assessed for TD, the DON stated "I would have to check our policy. No further information was provided. Policies were requested but not provided. On 5/14/15, at approximately 6:00 p.m. LPN-A stated to the surveyor that the consultant pharmacist would not be available until Monday, 5/18/15. LPN-A further stated she had the	F 428		

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F 428	Continued From page 27 surveyor contact information and would communicate contact information to consultant pharmacist. On 5/22/15, at 1:45 p.m. consulted pharmacist was called but was unable to be reached.	F 428	**F 431** **6-15-15** A new padlock was placed on the emergency medication box during the survey. The emergency medication box will be locked and attached to the refrigerator ro prevent both its removal from the refrigerator and to prevent only authorized individuals from gaining access to the medication box. Only the nursing staff have a key to the medication box. No other staff can gain accces to the box. The administrator will be responsible for ensuring that this practice is followed, in keeping with the facility policy.	
F 431 SS=F	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 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	F 431		

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F 431	Continued From page 28 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 safe and secure medication storage of emergency medication kit. This had the potential to affect all 21 residents in the facility. Findings include: During observation of medication storage, on 5/14/15, at 6:58 p.m. licensed practical nurse (LPN)-A informed surveyor the facility's emergency kit was stored in the refrigerator in the kitchen area. When LPN-A and the surveyor entered the kitchen, the door was found unlocked. LPN-A opened the refrigerator and removed the emergency kit, which had an open padlock on the outside of the container. LPN-A removed the padlock, and the contents of the emergency kit included unopened injectable medication including insulin, Ativan (antianxiety) and Risperdal Consta (antipsychotic). During an interview on 5/15/15, at 2:45 p.m. the director of nursing and administrator explained that the staff generally pulled the kitchen door shut and sometimes locked the door. The staff stated the emergency kit should have always been locked with the padlock and the nurse was the only staff who had the key. A policy was requested but not provided.	F 431		

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F 458 F 458 SS=E	Continued From page 29 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide 80 square feet of floor space per resident as required in rooms 103, 104, 205, 206, and 207. That had the potential to affect 12 of 12 residents (R2, R3, R4, R5, R6, R7, R8, R9, R11, R17, R18, R21) who resided in those rooms. Findings include: Resident rooms 103, 104, 205, 206, and 207 did not meet the required 80 square feet per resident for multiple resident bedrooms. The room sizes list was provided by the administrator on 1/15/13, and indicated: Room 103 had 236.56 square feet, 78.85 square feet per resident Room 104 had 230.77 square feet, 76.92 square feet per resident Room 205 had 117.40 square feet, 58.7 square feet per resident Room 206 had 138.96 square feet, 69.48 square feet per resident Room 207 had 145.44 square feet, 72.72 square feet per resident The rooms were observed to pose no safety	F 458 F 458	**F 458** **6-15-15** Waiver Most rooms meet the state guidelines for resident room size and the current facility has operated as a nursing home for over 50 years with no change in the number of residents per room. A waiver renewal will be requested for the approximately nine (9) square feet needed per resident on average in each of these five rooms. (Please see copy of waiver renewal request attached.) Variations are in accordance with the particular need of each resident and will not adversely affect the health or safety of the residents. The room size waiver was disclosed to the residents who occupy the rooms by the Administrator and signed copies are in their charts. The Administrator presents the room size disclosure to future residents in the Admission Agreement.	

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F 458	Continued From page 30 hazards and were furnished adequately. There was no evidence these residents were negatively impacted by their room size. The residents had been informed of the room size prior to admission and offered no complaints regarding their rooms during the survey. On 5/11/15, at 1:30 p.m. during the entrance conference, the administrator verified the above findings, and stated the facility had previously requested a waiver for the requirement.	F 458	**F 501** **7-15-15** The facility will designate a physician to serve as medical director of LMCC. The medical director will be responsible for implementation of resident care policies and the coordination of medical care in the facility. The administrator will be responsible for recruiting a physician for the position of medical director.	
F 501 SS=C	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a physician served as a medical director of the facility. This deficient practice had the potential to affect all 21 residents currently residing in the facility. Findings include: During the entrance conference on 5/11/15, at 1:35 p.m. with the administer and director of nursing, the administrator stated the medical director left employment with the facility in 11/14. In a follow up interview on 5/15/15, at 1:20 p.m.	F 501		

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F 501	Continued From page 31 the administrator explained that the medical director left the facility on 11/1/14, and the facility has been without a medical director since that time. The administrator reported they were having difficulty finding a physician willing to perform medical director role and stated he was attempting to get the previous director who served in the role for many years to return. A policy was requested but not provided.	F 501	**F 520** **7-30-15** While the facility conducted two Quality Assurance meetings in the past year, QA meetings will be held quarterly in January, April, July and October of each year. The facility will have the Medical Director, DON, Administrator, Director of Resident Services and other LMCC personnel as members of the committee. The Administrator will be responsible for overseeing the full implementation of this provision.	
F 520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	F 520		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING _____ B. WING _____	05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

(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 520	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee met quarterly as required and maintained required members. This had the potential to affect all 21 residents residing in the facility. Findings include: Review of the quality assurance meeting attendance logs from 5/1/14 to 5/14/15, identified the facility QAA committee met twice on 5/25/14 and 10/22/14, and held no meetings in 2015. The medical director attended the 5/28/14 meeting, but not the 10/22/14 meeting. This was a period of greater than 11 months between QAA meetings and attendance by the medical director which exceeded the quarterly requirement and need for medical director attendance. During interview on 5/15/15, at 1:20 p.m. the administrator explained that the QAA met every six months, but acknowledged a meeting was not held every six months over the past year. The administrator stated the previous medical director left the facility on 11/1/14, and the facility had been without a medical director since that time. A policy was requested but not provided.	F 520		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0389

June 8, 2015

Mr. Jeff Sprinkel, Administrator
Lake Minnetonka Care Center
20395 Summerville Road
Deephaven, Minnesota 55331

RE: Project Number F5606023

Dear Mr. Sprinkel:

Please Note: Health and Life Safety Code surveys are being processed under separate enforcement cycles. Health survey findings have been sent to you already.

On June 4, 2015, a standard survey was completed at your facility by the Minnesota Department of 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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>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;

Potential Consequences - 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.

CONTACT INFORMATION

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0525

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 July 14, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 14, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter.

Your PoC 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,

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 September 4, 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 December 4, 2015 (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 a PoC 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

Enclosure

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

F5606023

PRINTED: 07/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA CARE CENTER	**20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331**

(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
K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Lake Minnetonka Care Center, was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 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.. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok w/FSES for K12 + 39 7-24-15 JS RECEIVED JUL 22 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 7-17-15

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Lake Minnetonka Care Center is a 2-story building with a partial basement. The building was constructed in 1920 and was determined to be of Type V(000) Construction. In 1960 an addition was constructed to the north and was determined to be of Type V(000). It is automatic fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitor for fire department notification. The facility has a capacity of 21 beds with a census of 19 at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a)is NOT MET as evidenced by:	K 000	K 012 7-15-15 To address the K12 Construction Type of Health Care Facilities, a FSES has been completed on the facility. Since there were no changes to the building and an FSES was completed last year, it again verified that a Two Story Building of Type V (000) construction with an automatic sprinkler system will meet or exceed the equivalency requirements for the facility. All previous FSESs that have been conducted have verified that the facility has been in compliance with the equivalency standards. There have been no alterations, changes or modifications to the building since the last FSES was completed. The administrator will be responsible for ensuring the FSES has been completed.	
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	K 012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 012	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, this building does not meet the requirement for construction type and height. This deficient practice could affect all residents. Findings include: On facility tour between 10:15 AM and 11:15 AM on 06/04/2015, observation revealed that this 2-story, wood frame facility of Type V(000) construction does not meet the minimum construction requirements for a building of this height. This deficient practice was verified by the administrator via telephone at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 012		
K 039 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3 This STANDARD is not met as evidenced by: Based on observation and interview, the second floor corridor does not meet the minimum 48" width requirement. This deficient practice could affect all residents.	K 039		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 039	Continued From page 3 Findings include: During a tour of the facility between 10:15 AM and 11:15 AM on 06/04/2015, observation revealed that portions of the first floor corridor are only 35" wide. This deficient practice was verified by the administrator via telephone at the time of the inspection. Note: This deficiency need not be corrected if an FSES can establish that the fire has an overall level of fire safety equivalent to that required by the Life Safety Code.	K 039	K039 6-30-15 Please see FSES.	
K 045 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide adequate emergency lighting in accordance with LSC (00) 19.2.8. This deficient practice can effect all residents. Findings include: During facility tour between 10:15 AM and 11:15 AM on 06/04/2015, record review revealed that the documented testing of the emergency lighting only occurred during 7 of the last 12 months.	K 045	K 045 6-30-15 The testing of the emergency lighting has been done for June and will be conducted on a monthly basis. The administrator will be responsible for including this testing along with other testing of the facility's safety systems. The testing will be documented on the facility's fire drill reports. The administrator will be responsible for the ensuring that the testing will be done on a monthly basis.	

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K 045	Continued From page 4 This deficient practice was verified by the administrator via telephone at the time of the inspection.	K 045	K062 6-30-15 The side wall fire sprinkler head has been repaired/replaced with the appropriate plug by a qualified licensed personnel. The administrator will be responsible for ensuring that this item is repaired and/or replaced appropriately.	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility has failed to inspect and maintain the sprinkler system in accordance with NFPA 13 and NFPA 25. This deficient practice could affect the residents. Findings include: On facility tour between 10:15 AM and 11:15 AM on 06/04/2015, observation revealed that there is a sidewall fire sprinkler head in a vertical position and is plumbed into the stored water pressure tank air line T-fitting upstream of the check valve. This deficient practice was verified by the administrator via telephone at the time of the inspection.	K 062		
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than	K 076	K076 6-15-15 The two portable liquid oxygen tanks have been removed from the nurses station and will not be stored inside the building. There will be no storage of liquid oxygen within the confines of the facility. The administrator will be responsible to ensure that no storage of oxygen tanks is done within the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/04/2015**

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K 076	Continued From page 5 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the medical gas storage in accordance with NFPA 99. This deficient practice could affect the residents. Findings include: During facility tour on between 10:15 AM and 11:15 AM on 06/04/2015, observation revealed that there are (2) portable liquid oxygen tanks being stored at the nurses station. This deficient practice was verified by the administrator via telephone at the time of the inspection.	K 076	K147 6-15-15 The three extension cords in use in rooms 206, 208 and the laundry room have been removed and discontinued. Extension cords will not be used within the facility . The administrator is responsible to see that extension cords are not being used in the facility at all.	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to comply with NFPA 70, The National Electric Code. This deficient practice could affect	K 147		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245606	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**06/04/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA CARE CENTER	**20395 SUMMERVILLE ROAD** **DEEPHAVEN, MN 55331**

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K 147	Continued From page 6 some residents. Findings include: On facility tour between 10:15 AM and 11:15 AM on 06/04/2015, observation revealed that there are extension cords in use in resident room(s) 206, 208 and the clothes washing machine. This deficient practice was verified by the administrator via telephone at the time of the inspection.	K 147		

Sheehan, Pat (DPS)

From: Sheehan, Pat (DPS)
Sent: Friday, July 24, 2015 10:37 AM
To: rochi_lsc@cms.hhs.gov
Cc: kerry.queen@state.mn.us; robert.rexeisen@state.mn.us; 'jrsprinkel@lmcare.com'; Dehler, Robert; Dietrich, Shellae (MDH); 'Fiske-Downing, Kamala'; Henderson, Mary (MDH); 'Johnston, Kate'; Leach, Colleen (MDH); marian.whitney@state.mn.us; Meath, Mark (MDH)
Subject: Lake Minnetonka Care Center (245606) 2015 FSES for K12 & 39 - Previously Approved - No changes

This is to inform you that I am accepting the FSES report that was conducted on 7-9-15 for Lake Minnetonka CC for k-tags 12 & 39. The exit date was 6-4-15.

I am recommending that CMS approve this FSES report.

Patrick Sheehan, Fire Safety Supervisor
Office: 651-201-7205 Cell: 651-470-4416
Health Care & Corrections Fire Inspections
Minnesota State Fire Marshal Division Est. 1905
445 Minnesota St., Suite 145, St Paul, MN 55101-5145
FAX: 651-215-0525
Web: fire.state.mn.us

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

F5606022

Form Approved
OMB No. 0938-0242

ZONE 01 OF 03 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
LAKE MINNETONKA CARE CENTER	01

ZONE(S) EVALUATED: BASEMENT

PROVIDER/VENDOR NO.	DATE OF SURVEY
245606	CMS: 6/4/2015; FSES: 7/9/2015

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values				
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable
	Risk Factor	1.0 ✓	1.6	3.2	4.5
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30
	Risk Factor	1.0 ✓	1.2	1.5	2.0
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1	1.2	1.4	1.6	1.6 ✓
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0 ✓	1.1	1.2	1.5	4.0
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor	1.0 ✓		1.2		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	1	X	1	X	1.6	X	1	X	1	=	1.60

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X		=	

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	1.60	=	1

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR/SIGNATURE Kenny Quinn	TITLE DEPUTY STATE FIRE MARSHAL	DATE 7/09/2015
FIRE AUTHORITY SIGNATURE	TITLE FIRE SAFETY SUPERVISOR	DATE 7-24-15

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values							
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II			-7
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433	
First	-2 ☐	0 ☐	-2 ☐	0 ☐	0 ☐	2 ☐	2 ☐	
Second	-7 ✓	-2 ☐	-4 ☐	-2 ☐	-2 ☐	2 ☐	4 ☐	
Third	-9 ☐	-7 ☐	-9 ☐	-7 ☐	-7 ☐	2 ☐	4 ☐	
4th and Above	-13 ☐	-7 ☐	-13 ☐	-7 ☐	-9 ☐	-7 ☐	4 ☐	
2. Interior Finish (Corridors and Exits)	Class C -5(0)[f] ☐	Class B 0(3)[f] ☐	Class A 3 ✓					3
3. Interior Finish (Rooms)	Class C -3(1)[f] ☐	Class B 1(3)[f] ☐	Class A 3 ✓					3
4. Corridor Partitions/Walls	None or Incomplete -10(0)[a] ☐	<½ hour 0 ✓	≥½ to <1 hour 1(0)[a] ☐	≥1 hour 2(0)[a] ☐				0
5. Doors to Corridor	No Door -10 ☐	<20 min FPR 0 ✓	≥20 min FPR 1(0)[d] ☐	≥20 min FPR and Auto Clos. 2(0)[d] ☐				0
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is				1
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft		
	-6(0)[b] ☐	-4(0)[b] ☐	-2(0)[b] ☐	-2(0)[c] ☐	0 ☐	1 ✓		
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.					0
			<1 hr	≥1 hr to <2 hr	≥2 hr			
	-14 ☐	-10 ☐	0 ✓	2(0)[e] ☐	3(0)[e] ☐			
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies			0
	In Zone	Outside Zone	In Zone	In Adjacent Zone				
	-11 ☐	-5 ☐	-6 ☐	-2 ☐	0 ✓			
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone					0
	-5(0)[c] ✓	0 ☐	3 ☐					
10. Emergency Movement Routes	<2 Routes	Multiple Routes						0
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)			
	-8 ☐	-2 ☐	0 ✓	1 ☐	5 ☐			
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm					2
			W/O F.D. Conn.	W/F.D. Conn				
	-4 ☐		1 ☐	2 ✓				
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone			5
	0(3)[g] ☐	2(3)[g] ☐	3(3)[g] ☐	4 ☐	5 ✓			
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building					10
	0 ☐	8 ☐	10 ✓					

NOTE:

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only)

[d] Use (0) where parameter 4 is -10.

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-7	-7		-7
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	0			0
5. Doors to Corridor	0		0	0
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			0	0
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		5	5	5
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 9	S_2= 10	S_3= 14	S_4= 17

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11 ☐	5 ☐	15(12)[a] ☐	4 ☐	8(5)[a] ☐	1 ☐
2nd or 3rd story[b]	15 ☐	9 ☑	17(14)[a] ☐	6 ☑	10(7)[a] ☐	3 ☑
4th story or higher	18 ☐	9 ☐	19(16)[a] ☐	6 ☐	11(8)[a] ☐	3 ☐

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 9	-	S_a 9	=	C 0	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 10	-	S_b 6	=	E 4	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 14	-	S_c 3	=	P 11	✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 17	-	R 1	=	G 16	✓	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	✓		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			✓
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	✓		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	✓		
E.	There are no flue-fed incinerators.	✓		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	✓		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	✓		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✓		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	✓		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	✓		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	✓		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			✓

CONCLUSIONS

1. ☑ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

F5606022

Form Approved
OMB No. 0938-0242

ZONE 02 OF 03 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
LAKE MINNETONKA CARE CENTER	01

ZONE(S) EVALUATED: FIRST FLOOR

PROVIDER/VENDOR NO.	DATE OF SURVEY
245606	CMS: 6/4/2015; FSES: 7/9/2015

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.
A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0 ☐	1.6 ☐	3.2 ☑	4.5 ☐	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0 ☐	1.2 ☐	1.5 ☑	2.0 ☐	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1 ☑	1.2 ☐	1.4 ☐	1.6 ☐	1.6 ☐
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0 ☐	1.1 ☐	1.2 ☐	1.5 ☑	4.0 ☐
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor	1.0 ☐		1.2 ☑		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.
A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.
B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.5	X	1.1	X	1.5	X	1.2	=	9.50

Step 3: Compute Adjusted Building Status (R) - Use Table 2.
A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.
B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.
C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	☐	=	☐

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	9.50	=	6

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE [signature]	TITLE DEPUTY STATE FIRE MARSHAL	DATE 7/09/2015
FIRE AUTHORITY SIGNATURE [signature]	TITLE FIRE SAFETY SUPERVISOR	DATE 7-24-15

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values							
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II			-2
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433	
First	-2 ✓	0	-2	0	0	2	2	
Second	-7	-2	-4	-2	-2	2	4	
Third	-9	-7	-9	-7	-7	2	4	
4th and Above	-13	-7	-13	-7	-9	-7	4	
2. Interior Finish (Corridors and Exits)	Class C -5(0)[f]	Class B 0(3)[f]	Class A 3 ✓					3
3. Interior Finish (Rooms)	Class C -3(1)[f]	Class B 1(3)[f]	Class A 3 ✓					3
4. Corridor Partitions/Walls	None or Incomplete -10(0)[a]	<½ hour 0	≥½ to <1 hour 1(0)[a] ✓	≥1 hour 2(0)[a]				1
5. Doors to Corridor	No Door -10	<20 min FPR 0	≥20 min FPR 1(0)[d] ✓	≥20 min FPR and Auto Clos. 2(0)[d]				1
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is				1
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft		
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	0	1 ✓		
7. Vertical Openings	Open 4 or More Floors -14	Open 2 or 3 Floors -10	Enclosed with Indicated Fire Resist. <1 hr 0 ✓	≥1 hr to <2 hr 2(0)[e]	≥2 hr 3(0)[e]			0
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies			0
	In Zone -11	Outside Zone -5	In Zone -6	In Adjacent Zone -2	0 ✓			
9. Smoke Control	No Control -5(0)[c] ✓	Smoke Barrier Serves Zone 0	Mech. Assisted Systems by Zone 3					0
10. Emergency Movement Routes	<2 Routes -8	Multiple Routes: Deficient -2 ✓	W/O Horizontal Exit(s) 0	Horizontal Exit(s) 1	Direct Exit(s) 5			-2
11. Manual Fire Alarm	No Manual Fire Alarm -4	Manual Fire Alarm: W/O F.D. Conn. 1	W/F.D. Conn 2 ✓					2
12. Smoke Detection and Alarm	None 0(3)[g]	Corridor Only 2(3)[g] ✓	Rooms Only 3(3)[g]	Corridor and Habit. Spaces 4	Total Spaces In Zone 5			2
13. Automatic Sprinklers	None 0	Corridor and Habit. Space 8	Entire Building 10 ✓					10

NOTE:

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only)

[d] Use (0) where parameter 4 is -10.

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-2	-2		-2
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	1		1	1
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		2	2	2
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 16	S_2= 12	S_3= 10	S_4= 19

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11 ☐	5 ☑	15(12)[a] ☐	4 ☑	8(5)[a] ☐	1 ☑
2nd or 3rd story[b]	15 ☐	9 ☐	17(14)[a] ☐	6 ☐	10(7)[a] ☐	3 ☐
4th story or higher	18 ☐	9 ☐	19(16)[a] ☐	6 ☐	11(8)[a] ☐	3 ☐

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 16	−	S_a 5	=	C 11	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 12	−	S_b 4	=	E 8	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 10	−	S_c 1	=	P 9	✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 19	−	R 6	=	G 13	✓	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	✓		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			✓
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	✓		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	✓		
E.	There are no flue-fed incinerators.	✓		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	✓		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	✓		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✓		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	✓		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	✓		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	✓		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			✓

CONCLUSIONS

1. ☑ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code*.*

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code*.*

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

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

F5606022

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OMB No. 0938-0242

ZONE 03 OF 03 ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

2000 LIFE SAFETY CODE

FACILITY	BUILDING
LAKE MINNETONKA CARE CENTER	01

ZONE(S) EVALUATED: SECOND FLOOR

PROVIDER/VENDOR NO.	DATE OF SURVEY
245606	CMS: 6/4/2015; FSES: 7/9/2015

COMPLETE THIS WORKSHEET FOR EACH ZONE. WHERE CONDITIONS ARE THE SAME IN SEVERAL ZONES, ONE WORKSHEET CAN BE USED FOR THOSE ZONES.

Step 1: Determine Occupancy Risk Parameter Factors - Use Table 1.

A. For each Risk Parameter in Table 1, select and circle the appropriate risk factor value. Choose only one for each of the five Risk Parameters.

TABLE 1. OCCUPANCY RISK PARAMETER FACTORS

Risk Parameters	Risk Factors Values					
1. Patient Mobility *(M)*	Mobility Status	Mobile	Limited Mobility	Not Mobile	Not Movable	
	Risk Factor	1.0 ☐	1.6 ☐	3.2 ☑	4.5 ☐	
2. Patient Density *(D)*	No. of Patients	1–5	6–10	11–30	>30	
	Risk Factor	1.0 ☐	1.2 ☑	1.5 ☐	2.0 ☐	
3. Zone Location *(L)*	Floor	1st	2nd or 3rd	4th to 6th	7th and Above	Basements
	Risk Factor	1.1 ☐	1.2 ☑	1.4 ☐	1.6 ☐	1.6 ☐
4. Ratio of Patients to Attendants *(T)*	Patients / Attendant	1–2 / 1	3–5 / 1	6–10 / 1	>10 / 1	One or More / None
	Risk Factor	1.0 ☐	1.1 ☐	1.2 ☐	1.5 ☑	4.0 ☐
5. Patient Average Age *(A)*	Age	Under 65 Years and Over 1 year		65 Years and Over 1 Year and Younger		
	Risk Factor	1.0 ☐		1.2 ☑		

Step 2: Compute Occupancy Risk Factor (F) - Use Table 2.

A. Transfer the circled risk factor values from Table 1 to the corresponding blocks in Table 2.

B. Compute F by multiplying the risk factor values as indicated in Table 2.

TABLE 2. OCCUPANCY RISK FACTOR CALCULATION

	M		D		L		T		A		F
OCCUPANCY RISK	3.2	X	1.2	X	1.2	X	1.5	X	1.2	=	8.30

Step 3: Compute Adjusted Building Status (R) - Use Table 2.

A. If building is classified as "NEW" use Table 3A. If building is classified as "Existing" use Table 3B.

B. Transfer the value of F from Table 2 to Table 3A or Table 3B as appropriate. Calculate R.

C. Transfer R to the block labeled R in Table 7 on page 4 of the work sheet.

TABLE 3A. (NEW BUILDINGS)

	F		R
1.0 X	☐	=	☐

TABLE 3B. (EXISTING BUILDINGS)

	F		R
0.6 X	8.30	=	5

*** FIRE/SMOKE ZONE is a space separated from all other spaces by floors, horizontal exits, or smoke barriers.**

SURVEYOR SIGNATURE Kerry Olson	TITLE DEPUTY STATE FIRE MARSHAL	DATE 7/09/2015
FIRE AUTHORITY SIGNATURE	TITLE FIRE SAFETY SUPERVISOR	DATE 7-24-15

Step 4: Determine Safety Parameter Values - Use Table 4.

A. Select and circle the safety value for each safety parameter in Table 4 that best describes the conditions in the zone. Choose only one value for each of the 13 parameters. If two or more appear to apply, choose the one with the lowest point value.

TABLE 4.

Safety Parameters	Safety Parameters Values							
1. Construction	Combustible Types III, IV, and V				NonCombustible Types I and II			-7
Floor or Zone	000	111	200	211 + 2HH	000	111	222, 332, 433	
First	-2	0	-2	0	0	2	2	
Second	-7 ✓	-2	-4	-2	-2	2	4	
Third	-9	-7	-9	-7	-7	2	4	
4th and Above	-13	-7	-13	-7	-9	-7	4	
2. Interior Finish (Corridors and Exits)	Class C	Class B	Class A					3
	-5(0)[f]	0(3)[f]	3 ✓					
3. Interior Finish (Rooms)	Class C	Class B	Class A					3
	-3(1)[f]	1(3)[f]	3 ✓					
4. Corridor Partitions/Walls	None or Incomplete	<½ hour	≥½ to <1 hour	≥1 hour				1
	-10(0)[a]	0	1(0)[a] ✓	2(0)[a]				
5. Doors to Corridor	No Door	<20 min FPR	≥20 min FPR	≥20 min FPR and Auto Clos.				1
	-10	0	1(0)[d] ✓	2(0)[d]				
6. Zone Dimensions	Dead End			No Dead Ends >30 ft and Zone Length Is				1
	>100 ft	>50 ft to 100 ft	30 ft to 50 ft	>150 ft	100 ft to 150 ft	<100 ft		
	-6(0)[b]	-4(0)[b]	-2(0)[b]	-2(0)[c]	0	1 ✓		
7. Vertical Openings	Open 4 or More Floors	Open 2 or 3 Floors	Enclosed with Indicated Fire Resist.					0
			<1 hr	≥1 hr to <2 hr	≥2 hr			
	-14	-10	0 ✓	2(0)[e]	3(0)[e]			
8. Hazardous Areas	Double Deficiency		Single Deficiency		No Deficiencies			0
	In Zone	Outside Zone	In Zone	In Adjacent Zone				
	-11	-5	-6	-2	0 ✓			
9. Smoke Control	No Control	Smoke Barrier Serves Zone	Mech. Assisted Systems by Zone					0
	-5(0)[c] ✓	0	3					
10. Emergency Movement Routes	<2 Routes	Multiple Routes						-2
		Deficient	W/O Horizontal Exit(s)	Horizontal Exit(s)	Direct Exit(s)			
	-8	-2 ✓	0	1	5			
11. Manual Fire Alarm	No Manual Fire Alarm		Manual Fire Alarm					2
			W/O F.D. Conn.	W/F.D. Conn				
	-4		1	2 ✓				
12. Smoke Detection and Alarm	None	Corridor Only	Rooms Only	Corridor and Habit. Spaces	Total Spaces In Zone			4
	0(3)[g]	2(3)[g]	3(3)[g]	4 ✓	5			
13. Automatic Sprinklers	None	Corridor and Habit. Space	Entire Building					10
	0	8	10 ✓					

NOTE:

[a] Use (0) where parameter 5 is -10.

[b] Use (0) where parameter 10 is -8.

[c] Use (0) on floor with fewer than 31 patients (existing buildings only)

[d] Use (0) where parameter 4 is -10.

For SI units: 1 ft = 0.3048 m

[e] Use (0) where Parameter 1 is based on first floor zone or on an unprotected type of construction (columns marked "000" or "200")

[f] Use ( ) if the area of Class B or C interior finish in the corridor and exit or room is protected by automatic sprinklers and Parameter 13 is 0; use ( ) if the room with existing Class C interior finish is protected by automatic sprinklers, Parameter 4 is greater than or equal to 1, and Parameter 13 is 0.

[g] Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.

Step 5: Compute Individual Safety Evaluations – Use Table 5.

A. Transfer each of the 13 circled Safety Parameter Values from Table 4 to every unshaded block in the line with the corresponding Safety Parameter in Table 5. For Safety Parameter 13 (Sprinklers) the value entered in the People Movement Safety column is recorded in Table 5 as ½ the corresponding value circled in Table 4.

B. Add the four columns, keeping in mind that any negative numbers deduct.

C. Transfer the resulting total values for S_1, S_2, S_3, S_G to blocks labeled S_1, S_2, S_3, S_G in Table 7 on page 4 of this sheet.

TABLE 5. INDIVIDUAL SAFETY EVALUATIONS

Safety Parameters	Containment Safety (S_1)	Extinguishment Safety (S_2)	People Movement Safety (S_3)	General Safety (S_4)
1. Construction	-7	-7		-7
2. Interior Finish (Corr. and Exit)	3		3	3
3. Interior Finish (Rooms)	3			3
4. Corridor Partitions/Walls	1			1
5. Doors to Corridor	1		1	1
6. Zone Dimensions			1	1
7. Vertical Openings	0		0	0
8. Hazardous Areas	0	0		0
9. Smoke Control			0	0
10. Emergency Movement Routes			-2	-2
11. Manual Fire Alarm		2		2
12. Smoke Detection and Alarm		4	4	4
13. Automatic Sprinklers	10	10	10 ÷ 2 = 5	10
Total Value	S_1= 11	S_2= 9	S_3= 12	S_4= 16

TABLE 6.
MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)

Zone Location	Containment (S_a)		Extinguishment (S_b)		People Movement (S_c)	
	New	Exist.	New	Exist.	New	Exist.
1st story	11 ☐	5 ☐	15(12)[a] ☐	4 ☐	8(5)[a] ☐	1 ☐
2nd or 3rd story[b]	15 ☐	9 ☑	17(14)[a] ☐	6 ☑	10(7)[a] ☐	3 ☑
4th story or higher	18 ☐	9 ☐	19(16)[a] ☐	6 ☐	11(8)[a] ☐	3 ☐

a. Use ( ) in zones that do not contain patient sleeping rooms.

b. For a 2nd story zone location in a sprinklered EXISTING facility, as an alternative to the mandatory safety requirement values set specified in the table, the following mandatory values *set* shall be permitted to be used: S_a=7, S_b=10, and S_c=7

Step 6: Determine Mandatory Safety Requirement Values - Use Table 6.

A. Using the classification of the building (i.e., New or Existing) and the floor where the zone is located circle the appropriate value in each of the three columns in Table 6.

B. Transfer the three circled values from Table 6 to the blocks marked S_a, S_b, and S_c in Table 7.

C. For each row check "Yes" if the value in the answer block is zero or greater. Check "No" if the value in the answer block is a negative number.

TABLE 7. ZONE FIRE SAFETY EQUIVALENCY EVALUATION									Yes	No
Containment Safety (S_1)	minus	Mandatory Containment (S_a)	≥ 0	S_1 11	−	S_a 9	=	C 2	✓	
Extinguishment Safety (S_2)	minus	Mandatory Extinguishment (S_b)	≥ 0	S_2 9	−	S_b 6	=	E 3	✓	
People Movement Safety (S_3)	minus	Mandatory People Movement (S_c)	≥ 0	S_3 12	−	S_c 3	=	P 9	✓	
General Safety (S_4)	minus	Occupancy Risk (R)	≥ 0	S_4 16	−	R 5	=	G 11	✓	

TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET				
Complete one copy of this worksheet for each facility. For each consideration, select and mark the appropriate column.		Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	✓		
B.	In new facilities only, life-support systems, alarms, emergency communication systems, and illumination of generator set locations are powered as prescribed by 18.5.1.2 and 18.5.1.3.			✓
C.	Heating and air conditioning systems conform with the air conditioning, heating, and ventilating systems requirements within Section 9.2, except for enclosure of vertical openings, which have been considered in Safety Parameter 7 of Worksheet 4.7.6.	✓		
D.	Fuel-burning space heaters and portable electrical space heaters are not used.	✓		
E.	There are no flue-fed incinerators.	✓		
F.	An evacuation plan is provided and fire drills conducted in accordance with 18.7.1/18.7.2 and 19.7.1/19.7.2.	✓		
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	✓		
H.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✓		
I.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	✓		
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	✓		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	✓		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			✓

CONCLUSIONS

1. ☑ All of the checks in Table 7 are in the "Yes" column. The level of fire safety is at least equivalent to that prescribed by the *Life Safety Code.**

2. ☐ One of more of the checks in Table 7 are in the "No" column. The level of fire safety is not shown by this system to be equivalent to that prescribed by the *Life Safety Code.**

*The equivalency covered by this worksheet includes the majority of considerations covered by the *Life Safety Code*. There are a few considerations that are not evaluated by this method. These must be considered separately. These additional considerations are covered in Table 8, the "Facility Fire Safety Requirements Worksheet." One copy of this separate worksheet is to be completed for each facility.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0358

June 3, 2015

Mr. Jeff Sprinkel, Administrator
Lake Minnetonka Care Center
20395 Summerville Road
Deephaven, Minnesota 55331

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5606024

Dear Mr. Sprinkel:

The above facility was surveyed on May 11, 2015 through May 14, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rule. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, PO Box 64900 St Paul Mn 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gayle Lantto at (651) 201-3794 or email: gayle.lantto@state.mn.us.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00234	A. BUILDING: _____ B. WING _____	05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKE MINNETONKA CARE CENTER	20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On May 11, 12, 13, and 14, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Health Regulation Division, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Certification P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and	2 255		

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2 255	Continued From page 2 assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee met quarterly as required and maintained required members. This had the potential to affect all 21 residents residing in the facility. Findings include: Review of the quality assurance meeting attendance logs from 5/1/14 to 5/14/15, identified the facility QAA committee met twice on 5/25/14 and 10/22/14, and held no meetings in 2015. The medical director attended the 5/28/14 meeting, but not the 10/22/14 meeting. This was a period of greater than 11 months between QAA meetings and attendance by the medical director which exceeded the quarterly requirement and need for medical director attendance. During interview on 5/15/15, at 1:20 p.m. the administrator explained that the QAA met every six months, but acknowledged a meeting was not held every six months over the past year. The administrator stated the previous medical director left the facility on 11/1/14, and the facility had been without a medical director since that time.	2 255		

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2 255	Continued From page 3 A policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and/or revise policies and procedures to ensure the quality assurance (QA) committee includes the required members and meets every quarter to ensure ongoing compliance. The administrator or designee could educate all appropriate staff on these policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 295	MN Rule 4658.0100 Subp. 4 Employee Orientation and In-Service Education Subp. 4. Coordination of in-service education programs. In a nursing home with over 90 beds, one person must be designated as responsible for coordination of all in-service education programs. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure direct care staff and supervisors were educated on dementia care as required. Findings include: During the entrance conference on 5/11/15 at 1:35 p.m. staff training related to dementia was requested to be reviewed.	2 295		

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2 295	Continued From page 4 No training documentation was provided during survey from 5/11/15 to 5/14/15. During phone call to director of nursing (DON) on 5/26/15, training documentation was again requested however not provided by facility. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise training related to dementia care for direct care staff and supervisors. The DON designee could educate all appropriate staff on the policies and procedures to ensure staff are educated on dementia care, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 295		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop care plan goals and interventions to address the use of high	2 560		

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2 560	Continued From page 5 risk medications for 2 of 5 residents (R7, R4) reviewed for unnecessary medications; for range of motion for 1 of 1 resident (R4) reviewed for range of motion; and to honor medication preference for 1 of 2 residents (R1) reviewed for dignity. Findings include: R7's care plan revised 11/29/13, did include the development of goals and interventions related to the use of high risk medications including laxatives, insulin, and those with known anticholinergic (drying) side effects. R7's current physician orders dated 4/10/15, revealed an order for the following medications which are known to have an anticholinergic effect (a class of drugs that block the action of the neurotransmitter acetylcholine in the brain and help to block involuntary movements of the muscles associated with certain diseases): 1) Artane (trihexyphen) 5 milligrams (mg) daily for extrapyramidyl side effects (EPSE); 2) Ditropan (oxybutynin) 5 mg twice daily for urinary incontinence; and 3) Symetrel (amantiadine) 100 mg every day for EPSE. The potential significant side effects of anticholinergic's included: dry mouth, blurred vision, constipation, drowsiness, sedation, hallucinations, memory impairment, difficulty urinating, confusion, delirium , decreased sweating and saliva, causing increased risk for falls and constipation. However, R7's care plan revised on 11/29/13, failed to identify use and risk of anticholinergic medication use, and monitoring interventions. R7 was also prescribed the following medications for constipation; Senna Lax 8.6 mg twice daily and Miralax one capful with juice or water everyday. The care plan revised on 11/29/13,	2 560		

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2 560	Continued From page 6	2 560		

failed to identify R7's risk for constipation, medication use, monitoring and potential interventions to decrease use for medication, such as increasing water, dietary adjustments, exercise.

R7 was also prescribed the following insulin for insulin dependent diabetes mellitus: Novolog (fast acting insulin) three time daily and per sliding scale based on blood glucose level and Lantus (long acting insulin) at bedtime. The care plan revised 11/29/13, identified R7 was prescribed a therapeutic low concentrated sugar and low potassium diet, however, the care plan revised on 11/29/13, did not identify the R7's risk for hypoglycemic and hyperglycemic incidents related to use of insulin and goal for glucose control.

R7 was also prescribed oxybutynin (Ditropan) 5 mg twice daily for urinary incontinence. The care plan revised on 11/29/13, indicated the resident had bladder incontinence related to improper toileting habits, however, a plan was lacking for the monitoring of efficacy of drug or potential tapering or discontinuation of the medication. R7's quarterly Minimum Data Set (MDS) dated 2/11/15, indicated R7 was occasionally incontinent of urine (less than seven times a week) and had no toileting plan.

R4's care plan did not address resident's limitations in range of motion and plan to maintain or minimize the risk for further decline.

R4 was observed on 5/12/15, at 3:14 p.m. to have contractures of both hands and knees without splint devices and/or braces. The following day R4 was observed at breakfast at 7:45 a.m. while totally assisted with breakfast by

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2 560	Continued From page 7 a nursing assistant (NA)-A. R4's care plan dated 11/3/12, identified a ADL (activities of daily living) functional problem related to transfers and locomotion (non-weight bearing) and total dependence on staff for performance. The interventions directed staff to use the mechanical lift for all transfers to/from bed to wheelchair and to propel resident in wheelchair to/from room to day room, deck, transportation vehicle. The care plan also identified a ADL functional problem related to dressing and personal hygiene related to total dependence on staff for performance. The care plan interventions under the area of eating/nutrition revised 11/1/13, directed staff to set up and serve all meals and staff to feed resident and provide 1:1 supervision for swallowing /choking. The care plan did not address R4's limitation in range of motion and plan to maintain or prevent further decline in range of motion. In an interview with the DON on 5/14/15, at 3:28 p.m. stated no ROM was currently being provided to R4, and the care plan did not include R4's limitation in ROM or plan to maintain or prevent further decline in range of motion. R4's care plan also did not address insomnia and non-pharmacological interventions to promote sleep and use of medication to prevention urinary tract infections. R4's current physician orders dated 4/6/15, included an order for Trazodone (antidepressant commonly prescribed for insomnia) 50 mg at bedtime. The medication was prescribed for insomnia, and was initiated prior to 6/4/14. R4's care plan revised 11/1/13, identified psychotropic drug however did not address insomnia, use of medication and	2 560		

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2 560	Continued From page 8 non-pharmacological interventions to promote sleep. In an interview with DON on 5/14/15, at 3:04 p.m. acknowledged the care plan did not include the use of the Trazodone, nor non-pharmacological interventions to promote sleep. R4's current physician orders dated 4/6/15, included an order for cephalexin (antibiotic) cap 250 mg take one four times a day for the 1st three days of the months for urinary tract infection (UTI) prevention which was started on 9/17/14. R4's care plan revised 11/3/13, identified a ADL (activities of daily living) functional problem related to toileting/risk of urinary incontinence to total dependence on staff for performance. The care plan did not direct staff to monitor for UTIs, nor was the use of prophylactic antibiotic included in the resident's care plan. In a follow up interview with DON on 5/14/15, at 4:58 p.m. she indicated R4 had a history of urinary tract infections, with the last infection in 5/14, and prior to that in 10/13. The DON indicated the medication was reduced from being administered for the first 10 days of the month to the first three days of the month on 6/13. The DON acknowledged the care plan did not include the use of the cephalexin. R1's care plan did not address resident's preferences related to medication delivery. On 5/12/15 at 9:01 a.m. during an interview with R1, resident stated that a staff person (licensed practical nurse or LPN-A) administered medication to him that "messes up" his stomach. R1 further indicated the nurse that the that worked during the day "does not give medication	2 560		

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2 560	Continued From page 9 that messes up" his stomach. R1's quarterly MDS dated 3/16/15, indicated R1 was cognitively impaired and identified a diagnosis of schizophrenia. R1's integrated progress notes revealed the following: 1) On 10/9/14 Informed by night nurse that NA had found resident's medication in the garbage in the day room...Informed him they were found in the garbage and did he know how they got there 'no I don't'...res [resident] kept coming coming back every few minutes stating those pills hurt my stomach." 2) On 10/22/14 the ombudsman called reporting he had received several calls from the resident regarding stomach problems that were not new to him. The ombudsman was informed the resident had been non-compliant with taking his medications, and had seen the physician twice that month. 3) On 10/28/14 "Ombudsman here...told him would not take meds from evening/noc [night] nurses, he feels that they are putting poison on his meds and it hurts his stomach...ingested ben gay [topical pain medication] earlier this year. Resident again stated that he would not accept meds from anyone working evening, noc shift but would accept from nurses that work during day. Call placed to [physician]. 5) On 10/30/14 Call to psychologist to inform of not taking meds from pm/eve [evening] nurse." R1's care plan revised 12/28/13, identified resident as having impaired cognitive function/dementia or impaired thought process related to impaired decision making secondary to long standing mental illness (paranoid schizophrenia). Interventions directed staff to administer medication as ordered. The plan, however, did not include the need to schedule	2 560		

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2 560	Continued From page 10 medications as possible during the day shift to promote R1's compliance with taking medications. In an interview with the DON, on 5/14/15, at 4:53 p.m. she explained she had been at the facility fewer than six months, but was aware resident care plans "are a problem." The DON explained she was prioritizing work and although she had planned to review all the resident care plans, had not found the time to do so. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure care plans are developed to ensure appropriate care of residents. The DON or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for monitoring for potential side effect of	2 565		

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2 565	Continued From page 11 antipsychotic medication for 2 of 5 (R4, R10) residents reviewed for unnecessary medications. Findings include: R4's current physician orders revealed an order dated 3/17/15, for haloperidol 0.5 mg twice daily for paranoid psychosis, which was increased to 1 mg twice daily on 4/7/15. The care plan dated 11/3/12, identified R4 as fall risk related to psychotropic medications. The interventions directed staff to observe for psychotropic drug side effects and report to physician, psychiatrist review every 30 days for efficacy and side effects and primary medical physician every 60 days or PRN (as needed) for efficacy and side effects and pharmacist review of psychotropic medications every month. R4's record revealed DISCUS was dated as being completed on 12/29/07. No further TD assessments were found in the record. In an interview with the DON on 5/14/15, at 3:04 p.m. indicated she was unable to find any DISCUS assessment since 12/29/07 for R4. R10's current physician orders signed 4/2/15, revealed an order for Invega (antipsychotic medication) 9 mg daily for obsessive compulsive disorder and bipolar disorder, started on 1/8/14. The care plan identified R10 as utilizing psychotropic medications (Invega, divalproex) related to bipolar disorder. The interventions directed staff to administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness every shift, monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, extrapyramidyl side	2 565		

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2 565	Continued From page 12 effects (shuffling gait, rigid muscles, shaking), frequent falls, refusal to eat, difficulty swallowing, dry mouth, depression, suicidal ideation, social isolation, blurred vision, diarrhea, fatigue, insomnia, loss of appetite, weight loss, muscle cramps, nausea, vomiting, behavior symptoms not usual to the person, pharmacist to review psychotropic medications monthly for efficacy, dosage and side effects, primary physician to evaluate all medication, including psychotropics meds [medications] every 60 days or PRN for efficacy, dosage, and side effects, psychiatrist to evaluate psychotropic drug medications monthly or PRN for efficacy, dosage and side effects. R10's record lacked evidence of orthostatic blood pressure monitoring related to antipsychotic medication use. Review of the record revealed no orthostatic blood pressure monitoring completed in last 11 months. R10's record revealed a DISCUS was not completed. In an interview with the DON on 5/14/15, at 4:46 p.m. stated she was unable to find any documentation in the record to indicate orthostatic blood pressures or assessment for TD side effects was done. The DON further stated she would call the attending psychiatrist to see if an assessment was done recently by psychiatrist. When questioned regarding how often a resident is assessed for TD, the DON stated "I would have to check our policy, but would guess once a year." No further information was provided, including a related policy. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or	2 565		

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2 565	Continued From page 13 designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nursing rehabilitative services to maintain or improve range of motion (ROM) for 1 of 1 resident (R4) reviewed for ROM. Findings include: R4 was observed on 5/12/15, at 3:14 p.m. to have contractures of both hands and knees without splint devices and/or braces. The	2 895		

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2 895	Continued From page 14 following day R4 was observed at breakfast at 7:45 a.m. while totally assisted with breakfast by a nursing assistant (NA)-A. During the afternoon of 5/13/15, at 1:12 p.m. NA-A transferred R4 from her wheelchair to bed using a mechanical lift. NA-A then assisted R4 in turning from side side to remove the mechanical lift transfer sheet. NA-A was interviewed on 5/13/15, at 1:14 p.m. and said she did not provide any range of motion exercises to R4. NA-A further explained she had not been instructed to complete ROM exercises for R4 and further stated R4 did not utilize any braces or splints. In an interview with the director of nursing (DON) on 5/11/15, at 5:22 p.m. she stated R4 had contractures of both knees, hands and hips. The DON further stated R4 had "refused" ROM exercises in the past. R4's quarterly Minimum Data Set (MDS) dated 4/28/15, included diagnoses of dementia and hemiplegia (paralysis of one side of the body). The MDS indicated R4 had cognitive impairment, was unable to walk, required extensive assistance with activities of daily living (ADLs), and had a ROM impairment on both sides of upper and lower extremities. The MDS also indicated R4 was not receiving restorative nursing, physical or occupational therapy. The care area assessment (CAA) dated 10/26/14, indicated "Resident has contracture's of her arms, wrists, fingers and legs ... Resident requires extensive assist with bed mobility and total assist with transfers, locomotion on/off the unit, dressing, eating, toileting, grooming and bathing." R4's care plan reviewed 11/3/12, indicated R4	2 895		

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2 895	Continued From page 15 was totally dependent on staff in ADLs. The intervention directed staff to use mechanical lift for all transfers and to propel wheelchair to and from destinations. In a follow up interview with the DON on 5/14/15, at 3:28 p.m. stated she had a previous conversation with R4's family in 3/15 or 4/15, and they indicated if the DON could "talk mom into it," they would pay for occupational or physical therapy evaluation. Although the DON had attempted to approach the resident about it, she had refused, but stated, "I should talk to her again." DON reviewed R4's chart and was unable to find any documentation of conversation with R4 or her family. The DON further indicated no ROM was currently being provided to R4. A policy was requested but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure care and services are provided to ensure appropriate care of residents regarding range of motion. The DON or designee could educate all appropriate staff on the policies and procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
21220	MN Rule 4658.0700 Subp. 1 Medical Director; Designation Subpart 1. Designation. A nursing home must designate a physician to serve as medical director.	21220		

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21220	Continued From page 16 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee met quarterly as required and maintained required members. This had the potential to affect all 21 residents residing in the facility. Findings include: Review of the quality assurance meeting attendance logs from 5/1/14 to 5/14/15, identified the facility QAA committee met twice on 5/25/14 and 10/22/14, and held no meetings in 2015. The medical director attended the 5/28/14 meeting, but not the 10/22/14 meeting. This was a period of greater than 11 months between QAA meetings and attendance by the medical director which exceeded the quarterly requirement and need for medical director attendance. During interview on 5/15/15, at 1:20 p.m. the administrator explained that the QAA met every six months, but acknowledged a meeting was not held every six months over the past year. The administrator stated the previous medical director left the facility on 11/1/14, and the facility had been without a medical director since that time. A policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could employ and designate a physician to serve as medical director of facility. The administrator or designee could develop, review, and/or revise policies and	21220		

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21220	Continued From page 17 procedures to ensure the facility consistently has a medical director to ensure ongoing compliance. The administrator or designee could educate all appropriate staff on these policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21220		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by:	21426		

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21426	Continued From page 18 Based on interview and document review, the facility failed to ensure 1 of 2 newly hired staff (Employee 1 (E-1) was screened for tuberculosis (TB) as required. Findings include: Two employees had been hired at the facility in the past four months. E-1 was a licensed practical nurse (LPN), and had been hired on 4/22/15. E-1's personnel file lacked evidence the employee had been screened for TB symptoms, as well as two-step Mantoux testing. The DON verified the symptom screen and Mantoux testing had not been performed, although E-1 had been providing direct resident care since 4/24/15. The DON reported the facility was utilizing the Minnesota Department of Health's (MDH) Rules and Recommendations for Tuberculosis Screening, Prevention, and Control in Minnesota Nursing Homes information. The MDH requirements for employees read, "A nursing home must ensure that all employees, prior to employment...show freedom from active tuberculosis...All employees...must have an intradermal tuberculin test with purified protein derivative (Mantoux) within three months prior to employment. " SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could ensure all staff have had symptom screening and TB testing to ensure no active disease prior to working with residents. An auditing tool could be developed to ensure all staff have been screened as required. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	21530		

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21530	Continued From page 20 This MN Requirement is not met as evidenced by: Based on interview and document review, the consultant pharmacist failed to ensure medication regimens were free from unnecessary medications for 4 of 5 residents (R9, R7, R4, R10) reviewed for unnecessary mediation use. Findings include: R9 was prescribed the antipsychotic, clozapine 50 mg daily since 8/4/14. R9's record, however, lacked evidence of monitoring in the previous nine months for the potential for orthostatic blood pressure monitoring (a sudden drop in blood pressure with position change, such as standing or sitting up from a lying position) related to antipsychotic use. The annual Minimum Data Set (MDS) dated 3/15/15, revealed the resident ambulated independently and had experienced two falls since the previous assessment period. Monthly consultant pharmacist reviews revealed no recommendations of drug irregularities over past 11 months for R9. R7 was prescribed the antipsychotic Seroquel as needed (PRN), however, specific target behaviors were not identified and potential side effects including orthostatic hypotension and tardive dyskinesia (or TD--neurological syndrome characterized by repetitive, involuntary movement long-term use of certain drugs, including antipsychotics). R7's current physician orders dated 4/10/15, revealed an order for Seroquel 50 milligrams (mg) as needed every four hours for agitation.	21530		

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21530	Continued From page 21 The medication was ordered on 12/12/14, by the attending psychiatrist. The Medication Administration Record (MAR) indicated R7 was administered Seroquel as follows during the previous four months: 1) In 1/15-- administered seven times for c/o anxiety five times, complaints of aviation one time and per resident request one time 2) In 2/15-- administered three times "res c/o anxiety, restlessness, sadness" and "outbursts/anxiety/crying." 3) In 3/15--administered one times for "yelling, screaming and swearing." 4) In 4/15--administered three times for "anxiety" as documented two of three times administered. R7's record revealed no evidence of orthostatic blood pressure monitoring having been completed in the previous 11 months. Fall Tracking Forms (incident reports) revealed R7 experienced the following falls in the last five months: 1) On 1/11/15, at 7:00 a.m. walking independently without use of walker, shoes and socks; 2) On 1/18/15, at 7:45 a.m. fell while ambulating independently but unwitnessed; 3) On 3/14/15, at 8:00 a.m. fell while ambulating independently in dayroom; 4) On 4/11/15, unknown time, fall while walking independently to bed; 5) On 4/17/15, at 7:30 a.m. fell to floor, resident reported she "'fainted'" but fall tracking form indicated "knees buckled." R7's record revealed a Dyskinesia Identification System Condensed User Scale (DISCUS), used to diagnose potential TD, was dated as last having been completed in 6/12. No further TD	21530		

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21530	Continued From page 22 assessments were found in the record. In addition, R7 was also prescribed oxybutynin (Ditropan) 5 mg twice daily for urinary incontinence, on 4/23/14. Physician progress notes from 6/6/14 to 3/26/15, lacked justification for the continued need of oxybutynin and whether the benefits outweighed potential anticholenergic side effects. R7's quarterly MDS dated 2/11/15, identified R7 as being occasionally incontinent of urine (fewer than seven episodes a week) with no toileting program. Monthly consultant pharmacist reviews from 6/30/14 to 4/12/15, revealed no recommendations of drug irregularities over past 10 months for R7. In an interview with the director of nursing (DON) on 5/14/15, at 4:46 p.m. she reported she was unable to find any documentation in R7's record to indicate orthostatic blood pressures or TD assessments had been completed. The DON further stated she would call the attending psychiatrist to see if an assessment had recently been completed in their office. When questioned about frequency of testing for TD for a resident on antipsychotic medication the DON stated, "I would have to check our policy, but would guess once per year." At 4:49 p.m. the DON stated that R7 was previously prescribed Haldol (antipsychotic) PRN, but was since it interfered with another medication, it was discontinued and Seroquel was added. The DON indicated she was unable to locate a related policy, and no further information was provided related to TD assessment. R4's was current physician orders dated 4/6/15,	21530		

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21530	Continued From page 23 included an order for Trazodone (antidepressant commonly prescribed for insomnia) 50 mg at bedtime. The medication was prescribed for insomnia, and was initiated prior to 6/4/14. R4's medical record lacked evidence of an assessment of sleep patterns, identification of potential causal factors for sleep disturbance, documentation of non-pharmacological interventions and the effectiveness of interventions tried prior to the initiation of the sleep aid and monitoring of hours of sleep to determine the effectiveness of the the sleep aid medication. In addition, no attempt at a dose reduction for greater than 11 months was attempted. R4's physician progress notes, revealed a note on 4/6/15, 2/215, 12/1/14 "Sleeping well." Also on 12/1/14, progress note indicated "Overall feels generally a little more fatigued than in the past." Review of the psychiatrist/physician progress notes revealed no documentation to justify the lack of a dose reduction and continued need of the Trazodone. R4's Night Shift Monthly Charting dated 1/1/15, under the category of Sleep Pattern, had a check mark on "sleeps through" and hand written note "Trazodone at HS [hours of sleep] for insomnia." In addition, on 12/8/14, it was also noted the resident "sleeps through." R4's integrated progress notes contained no documentation related to monitoring of hours of sleep or non-pharmacological interventions utilized to promote sleep. Upon further review of the record, no documentation of a sleep assessment to identify potential contributing factors and potential non-pharmacological	21530		

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21530	Continued From page 24 interventions to promote sleep and monitoring of sleep hours to determine efficacy of medication was found. The monthly consultant pharmacist reviews from 6/30/14 to 4/12/15, revealed no recommendations of drug irregularities over past 10 months for R4. R4's current physician orders also revealed an order dated 3/17/15, for haloperidol 0.5 mg twice daily for paranoid psychosis, which was increased to 1 mg twice daily on 4/7/15. Further review revealed a DISCUS completed 12/29/07. No further TD assessments were found in the record. In an interview with the DON on 5/14/15, at 3:04 p.m. she verified the facility currently had no system for monitoring hours of sleep or a sleep hygiene assessment for residents who utilized medication to promote sleep. The DON explained nursing staff had been completing a monthly flow sheet that contained check boxes related to sleep patterns. The flow sheet had noted 1) sleeps through; 2) awake on and off; and 3) sleep less than four hours. The use of the flow sheet had been discontinued in 1/15. The DON reported she was unable to find any DISCUS assessment since 12/29/07 for R4. R10's current physician orders signed 4/2/15, revealed an order for Invega (antipsychotic medication) 9 mg daily for obsessive compulsive disorder and bipolar disorder, started on 1/8/14. The record for R10 lacked evidence of orthostatic blood pressure monitoring related to antipsychotic medication use, and no orthostatic blood pressure monitoring had been recorded in the previous 11 months. In addition, a DISCUS had not completed.	21530		

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21530	Continued From page 25 The monthly consultant pharmacist reviews from 6/30/14 to 4/12/15 revealed no recommendations of drug irregularities over past 10 months. In an interview with the DON on 5/14/15, at 4:46 p.m. stated she was unable to find any documentation in the record to indicate orthostatic blood pressures or a TD assessment. The DON further stated she would call the attending psychiatrist to see if an assessment was completed recently by psychiatrist. When questioned regarding how often a resident was assessed for TD, the DON stated "I would have to check our policy. No further information was provided. Policies were requested but not provided. On 5/14/15, at approximately 6:00 p.m. LPN-A stated to the surveyor that the consultant pharmacist would not be available until Monday, 5/18/15. LPN-A further stated she had the surveyor contact information and would communicate contact information to consultant pharmacist. On 5/22/15, at 1:45 p.m. consulted pharmacist was called but was unable to be reached. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage and educate nursing staff as necessary. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		

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21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor for potential side effect of antipsychotic medication and/or to ensure efficacy of sleep medication was documented for 4 of 5 (R9, R7, R4, R10) residents reviewed for unnecessary medications. Findings include: R9 was prescribed the antipsychotic, clozapine	21535		

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21535	Continued From page 27 50 mg daily since 8/4/14. R9's record, however, lacked evidence of monitoring in the previous nine months for the potential for orthostatic blood pressure monitoring (a sudden drop in blood pressure with position change, such as standing or sitting up from a lying position) related to antipsychotic use. The annual Minimum Data Set (MDS) dated 3/15/15, revealed the resident ambulated independently and had experienced two falls since the previous assessment period. R7 was prescribed the antipsychotic Seroquel as needed (PRN), however, specific target behaviors were not identified and potential side effects including orthostatic hypotension and tardive dyskinesia (or TD--neurological syndrome characterized by repetitive, involuntary movement long-term use of certain drugs, including antipsychotics). On 5/13/15, at 7:55 a.m. R7 was observed sitting at nursing station administering her insulin with supervision. Later in the afternoon, at 2:25 p.m. R7 was assisted by a nursing assistant (NA)-B ambulating with a walker in the hallway. R7's current physician orders dated 4/10/15, revealed an order for Seroquel 50 milligrams (mg) as needed every four hours for agitation. The medication was ordered on 12/12/14, by the attending psychiatrist. The Medication Administration Record (MAR) indicated R7 was administered Seroquel as follows during the previous four months: 1) In 1/15-- administered seven times for c/o anxiety five times, complaints of aviation one time and per resident request one time 2) In 2/15-- administered three times "res c/o anxiety, restlessness, sadness" and "outbursts/anxiety/crying."	21535		

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21535	Continued From page 28 3) In 3/15--administered one times for "yelling, screaming and swearing." 4) In 4/15--administered three times for "anxiety" as documented two of three times administered. R7's quarterly MDS dated 2/11/15, indicated the resident was cognitively intact, and was independent in bed mobility, transferring and walking in room, and with supervision outside of the room. Diagnoses on the MDS included hypertension, diabetes, schizophrenia, anxiety, depression and Parkinson's disease. The MDS indicated R7 showed minimal signs of depression and exhibited no behavioral problems. R7 had taken antidepressant and antipsychotic medication daily for the last seven days of the assessment period. The care plan dated 11/29/13, identified R7 as having potential the potential to be verbally aggressive (yelling, excessive profanity, slamming doors) related to mental, emotional illness, ineffective coping skills, having poor impulse control most commonly in response to redirections/correction or if she felt she was not getting enough attention from others. The goal statement was, "resident will have no more than 1 angry outburst per week." Interventions directed staff to administer medications as ordered, monitor/document for side effects and effectiveness. The care plan also identified R7 as utilizing psychotropic medications (clozapine, Cymbalta, divalproex ER, and Seroquel as needed) related to schizoaffective disorder, depression and anxiety. The interventions directed staff to administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness every shift, consult with pharmacy and psychiatrist every 30 days and primary medical physician every 60 days for	21535		

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efficacy, side effects, and dosage reduction if applicable, educate the resident/caregivers about risks, benefits and the side effects and/or toxic symptoms of psychotropic medication, monitor/document/report PRN any adverse reactions of psychotropic medications: unsteady gait, tardive dyskinesia, extrapyramidyl side effects (shuffling gait, rigid muscles, shaking).

R7's record revealed no evidence of orthostatic blood pressure monitoring having been completed in the previous 11 months. Fall Tracking Forms (incident reports) revealed R7 experienced the following falls in the last five months:

1) On 1/11/15, at 7:00 a.m. walking independently without use of walker, shoes and socks;
2) On 1/18/15, at 7:45 a.m. fell while ambulating independently but unwitnessed;
3) On 3/14/15, at 8:00 a.m. fell while ambulating independently in dayroom;
4) On 4/11/15, unknown time, fall while walking independently to bed;
5) On 4/17/15, at 7:30 a.m. fell to floor, resident reported she "'fainted'" but fall tracking form indicated "knees buckled."

R7's record revealed a Dyskinesia Identification System Condensed User Scale (DISCUS), used to diagnose potential TD, was dated as last having been completed in 6/12. No further TD assessments were found in the record.

In addition, R7 was also prescribed oxybutynin (Ditropan) 5 mg twice daily for urinary incontinence, on 4/23/14. Physician progress notes from 6/6/14 to 3/26/15, lacked justification for the continued need of oxybutynin and whether the benefits outweighed potential anticholenergic

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21535	Continued From page 30 side effects. R7's quarterly MDS dated 2/11/15, identified R7 as being occasionally incontinent of urine (fewer than seven episodes a week) with no toileting program. The care plan revised on 11/29/13, indicated the resident had bladder incontinence related to improper toileting habits. The goal stated "The resident will be continent during waking hours. The interventions directed staff to check every two hours during the night and as required for incontinence, wake every two hours at night to void and monitor for signs and symptoms of urinary tract infection. In an interview with the director of nursing (DON) on 5/14/15, at 4:46 p.m. she reported she was unable to find any documentation in R7's record to indicate orthostatic blood pressures or TD assessments had been completed. The DON further stated she would call the attending psychiatrist to see if an assessment had recently been completed in their office. When questioned about frequency of testing for TD for a resident on antipsychotic medication the DON stated, "I would have to check our policy, but would guess once per year." At 4:49 p.m. the DON stated that R7 was previously prescribed Haldol (antipsychotic) PRN, but was since it interfered with another medication, it was discontinued and Seroquel was added. The DON indicated she was unable to locate a related policy, and no further information was provided related to TD assessment. R4's was current physician orders dated 4/6/15, included an order for Trazodone (antidepressant commonly prescribed for insomnia) 50 mg at	21535		

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21535	Continued From page 31 bedtime. The medication was prescribed for insomnia, and was initiated prior to 6/4/14. R4's medical record lacked evidence of an assessment of sleep patterns, identification of potential causal factors for sleep disturbance, documentation of non-pharmacological interventions and the effectiveness of interventions tried prior to the initiation of the sleep aid and monitoring of hours of sleep to determine the effectiveness of the the sleep aid medication. In addition, no attempt at a dose reduction for greater than 11 months was attempted. During the morning of 5/13/15, at 7:45 a.m. NA-A was observed providing total assistance to R4 with her breakfast. In the afternoon at 1:12 p.m. NA-A transferred R4 from her wheelchair to bed using a mechanical lift. NA-A then assisted R4 in turning from side side to remove the mechanical lift transfer sheet. R4's physician progress notes, revealed a note on 4/6/15, 2/215, 12/1/14 "Sleeping well." Also on 12/1/14, progress note indicated "Overall feels generally a little more fatigued than in the past." Review of the psychiatrist/physician progress notes revealed no documentation to justify the lack of a dose reduction and continued need of the Trazodone. R4's quarterly MDS dated 1/26/15, identified cognitive impairment and a diagnosis of dementia. The MDS also identified mood symptoms of feeling tired or having little energy, and utilizing a antidepressant medication daily over the last seven days of the assessment period.	21535		

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	00234	A. BUILDING: _____ B. WING _____	05/14/2015

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21535	Continued From page 32 R4's Night Shift Monthly Charting dated 1/1/15, under the category of Sleep Pattern, had a check mark on "sleeps through" and hand written note "Trazodone at HS [hours of sleep] for insomnia." In addition, on 12/8/14, it was also noted the resident "sleeps through." R4's care plan dated 11/3/12, identified a mood/behavior problem related to dementia, delusions and being critical of others, but lacked identification of problems with insomnia. R4's integrated progress notes contained no documentation related to monitoring of hours of sleep or non-pharmacological interventions utilized to promote sleep. Upon further review of the record, no documentation of a sleep assessment to identify potential contributing factors and potential non-pharmacological interventions to promote sleep and monitoring of sleep hours to determine efficacy of medication was found. R4's current physician orders also revealed an order dated 3/17/15, for haloperidol 0.5 mg twice daily for paranoid psychosis, which was increased to 1 mg twice daily on 4/7/15. Further review revealed a DISCUS completed 12/29/07. No further TD assessments were found in the record. In an interview with the DON on 5/14/15, at 3:04 p.m. she verified the facility currently had no system for monitoring hours of sleep or a sleep hygiene assessment for residents who utilized medication to promote sleep. The DON explained nursing staff had been completing a monthly flow sheet that contained check boxes related to sleep patterns. The flow sheet had noted 1) sleeps through; 2) awake on and off; and 3) sleep less than four hours. The use of the flow sheet had	21535		

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21535	Continued From page 33 been discontinued in 1/15. The DON reported she was unable to find any DISCUS assessment since 12/29/07 for R4. R10 was observed on 5/13/15, at 8:15 a.m. ambulating independently and visiting with other residents sitting in dayroom area. The resident's current physician orders signed 4/2/15, revealed an order for Invega (antipsychotic medication) 9 mg daily for obsessive compulsive disorder and bipolar disorder, started on 1/8/14. R10's quarterly MDS dated 3/29/15, identified the resident had no cognitive impairment and had diagnoses of hypertension, bipolar disease, schizophrenia. The resident had utilized antipsychotic medication daily over the previous seven days during the assessment period. The MDS also identified R10 as being independent in bed mobility, transferring and walking. The record for R10 lacked evidence of orthostatic blood pressure monitoring related to antipsychotic medication use, and no orthostatic blood pressure monitoring had been recorded in the previous 11 months. In addition, a DISCUS had not completed. In an interview with the DON on 5/14/15, at 4:46 p.m. stated she was unable to find any documentation in the record to indicate orthostatic blood pressures or a TD assessment. The DON further stated she would call the attending psychiatrist to see if an assessment was completed recently by psychiatrist. When questioned regarding how often a resident was assessed for TD, the DON stated "I would have to check our policy. No further information was provided.	21535		

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21535	Continued From page 34 Policies were requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure resident's medications regimes are free from unnecessary medications. The DON or designee could educate all appropriate staff on the policies and procedures and could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safe and secure medication storage of emergency medication kit. This had the potential to affect all 21 residents in the facility. Findings include: During observation of medication storage, on 5/14/15, at 6:58 p.m. licensed practical nurse (LPN)-A informed surveyor the facility's emergency kit was stored in the refrigerator in the kitchen area. When LPN-A and the surveyor	21610		

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21610	Continued From page 35 entered the kitchen, the door was found unlocked. LPN-A opened the refrigerator and removed the emergency kit, which had an open padlock on the outside of the container. LPN-A removed the padlock, and the contents of the emergency kit included unopened injectable medication including insulin, Ativan (antianxiety) and Risperdal Consta (antipsychotic). During an interview on 5/15/15, at 2:45 p.m. the director of nursing and administrator explained that the staff generally pulled the kitchen door shut and sometimes locked the door. The staff stated the emergency kit should have always been locked with the padlock and the nurse was the only staff who had the key. A policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop policies and procedures to ensure medications are stored securely and only accessible to authorized staff. The DON or designee could educate all appropriate staff on these policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21610		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in	21942		

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21942	Continued From page 36 participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to establish a family council at least once every calendar year as required. That had the potential to affect all 21 residents in the facility. Findings include: A letter dated 1/31/14, regarding the facility's attempts at forming a family council was provided by the administrator. When the administrator was interviewed on 5/15/15, at 1:45 p.m. he stated he thought the last attempt to form a family council had been made in the last year, but acknowledged the last attempt had been greater than a year prior (15 months). SUGGESTED METHOD OF CORRECTION: The administrator or designee could delegate an individual to be responsible for the annual attempt to establish a family council/group. That individual would need to document efforts at forming a council, and identify when the attempt occurred in the calendar year. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		