DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: GWJG Facility ID: 00234

	IANI I -	TO BE COMIT		IIIE SIAI	E SURVET AGENCI		racinty ID. 00234
MEDICARE/MEDICAID PROVIDE (L1) 245606 2.STATE VENDOR OR MEDICAID N (L2) 519842900		3. NAME AND AI (L3) LAKE MINI (L4) 20395 SUMI (L5) DEEPHAVE	NETONKA C. MERVILLE F	ARE CENT	(L6) 55331	4. TYPE OF AC 1. Initial 3. Termination 5. Validation	TION: 7 (L8) 2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF C	WNERSHIP	7. PROVIDER/SU		GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey	9. Other
6. DATE OF SURVEY 08/12/ 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR EN	NDING DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	21 (L18) 21 (L17)	Complianc1. A B. Not in Con		gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SI 5. Life Safety Code * Code: A, 8	6. Scope o 7. Medical	f Services Limit Director Room Size
14. LTC CERTIFIED BED BREAKDOV	VN	L			15. FACILITY MEETS		
18 SNF 18/19 SNF 21 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		1861 (e) (1) or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMA				DATE):			
See Attached Remarks	ikks (ii Ai i Lica	ABLE SHOW LICE	ANCELLATION	DAIL).			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	Y APPROVAL	Date:
Jane Teipel, HFE NEI	[0	08/21/2015	(L19)	Mark Meath	、, Enforcement Sp	08/21/2015 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S	STATE AGENCY	
DETERMINATION OF ELIGIBILI X 1. Facility is Eligible to Pa 2. Facility is not Eligible			IPLIANCE WITH	H CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Abov	ol Interest Disclosure S	
22. ORIGINAL DATE	23. LTC AGREEI	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION 07/02/1992	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00- 01-Merger, Closure	05-Fai	LUNTARY I to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs 03-Risk of Involuntary Termination	on	l to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:			04-Other Reason for Withdrawal	OTHE	<u>R</u> wider Status Change
(L27)		uspension Date:	(L44) (L45)			00-Ac	tive
28. TERMINATION DATE:	29	O. INTERMEDIARY/	/CARRIER NO.		30. REMARKS		
	(L28)	03001		(L31)			
31. RO RECEIPT OF CMS-1539		2. DETERMINATION 07/28/2015	N OF APPROVAI		Posted 09/22/2015 Co		
	(L32)			(L33)	DETERMINATION APP	KUVAL	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00234

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.



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



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 Weath

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



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

Lake Minnetonka Care Center August 21, 2015 Page 2

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 Meeth

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)

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245606	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/12/2015	
Name of Facility LAKE MINNETONKA CARE CENTER			Street Address, City, State, Zip Code		
			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)	ltem	((Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0242		_06/15/2015		ID Prefix	F0279		06/23/2015		ID Prefix	F0282		06/23/2015
	483.15(b)		_		ū	483.20(d), 483.20(k)(1	1)				483.20(k)(3)(ii)		_
LSC			-		LSC				Ш.	LSC			
			Correction					Correction					Correction
ID Prefix	F0318		Completed 06/23/2015		ID Prefix	F0329		Completed 06/23/2015		ID Prefix	F0428		Completed 06/23/2015
	483.25(e)(2)		= ' ' ' ' ' ' ' '			483.25(I)		=			483.60(c)		= ' ' ' ' ' '
LSC			-		LSC	403.23(1)					403.00(C)		_
			-	-					+-				_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix	F0431		06/15/2015		ID Prefix			-		ID Prefix	F0501		06/18/2015
-	483.60(b), (d),	(e)	_		Reg. #					-	483.75(i)		_
LSC			-		LSC					LSC			_
			Correction					Correction					Correction
ID Prefix	F0520		Completed 06/15/2015		ID Prefix			Completed		ID Prefix			Completed
Peg #	483.75(o)(1)		_		Reg. #								_
•	403.75(0)(1)		-		LSC			-		LSC			_
			-	-				•	+-				-
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Prefix			-		ID Prefix			-		ID Prefix			_
Reg. #			_		Reg. #					Reg. #			_
LSC			-		LSC				Ш.	LSC			_
Reviewed By	′	Reviewed	-		te:	Signature of	Surve					Date:	
State Agency	/	GL/mm	1	0	8/21/20	15		339	37			08/12	2/2015
Reviewed By	<i>ı</i> —	Reviewed	Ву	Da	te:	Signature of	Surve	yor:				Date:	
CMS RO													
Followup to Survey Completed on: Check for any Uncorr							-						
	5/14/	2015				Uncor	rrecte	d Deficiencies	(CM	S-2567) Sent	to the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245606	(Y2) Multiple Con A. Building B. Wing	IN BUILDING	(Y3) Date of Revisit 7/28/2015
Name of Facility		Street Address, City, State, Zip Code	
LAKE MINNETONKA CARE CENTER		20395 SUMMERVILLE ROAD	
		DEEDHAVEN 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	-		Correction Completed 07/15/2015				Correction Completed 06/30/2015					Correction Completed 06/30/2015
_	NFPA 101 K0012		-	_	NFPA 101 K0039		-		•	NFPA 101 K0045		
_	NFPA 101 K0062		Correction Completed 06/30/2015	Reg. #	NFPA 101 K0076		Correction Completed 06/15/2015		Reg. #	NFPA 101 K0147		Correction Completed 06/15/2015
ID Prefix Reg. # LSC			Correction Completed	Reg. #			Correction Completed		Reg. #			Correction Completed —
ID Prefix Reg. # LSC	·		Correction Completed	Reg. #			Correction Completed					Correction Completed —
ID Prefix Reg. # LSC			-	Reg. #								
Reviewed I		Reviewed	I Ву	Date:	Signatu	ire of Sui	rveyor:				Date:	
	Зу	Reviewed	I By	Date:	Signatu	re of Sui	rveyor:				Date:	
Followup t	o Survey Co 6/4/2	•	າ:							Summary of the Facility?		NO



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 Weath

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 00234	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/12/2015
Name	of Facility		Street Address, City, State, Zip Code	
LA	KE 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	(Y4)	Item		(Y5)	Date	(Y4)	Item		(Y5) D	ate
		Cor	rection					Correction					Correction
ID Prefix	20255		npleted 1 5/2015	ļ "	D Prefix	20295		Completed 08/12/2015		ID Prefix	20560		Completed 06/23/2015
			13/2013	"							-		=
Reg. # LSC	MN Rule 4658.0070				Reg. #	MN Rule 4658.0100	Subp. 4	•		Reg. # LSC	MN Rule 4658	.0405 Subp.	2
		Con	rection					Correction					Correction
			npleted	l .				Completed					Completed
ID Prefix	20565	06/2	23/2015	"	D Prefix	20895		06/23/2015		ID Prefix	21220		_06/18/2015
Reg. # LSC	MN Rule 4658.0405 Su	ıbp. 3			Reg. # LSC	MN Rule 4658.0525	Subp. 2	2.B		Reg. # LSC	MN Rule 4658	.0700 Subp.	1
					130								<u> </u>
		Con	rection					Correction					Correction
ID Prefix	21426		npleted 12/2015		D Prefix	21520		Completed 06/23/2015		ID Prefix	24525		Completed 06/23/2015
				"				00/23/2013			-		-
Reg. # LSC	MN St. Statute 144A.0	4 Subd. :			Reg. # LSC	MN Rule 4658.1310	A.B.C			Reg. # LSC	MN Rule4658.		-
				-									
		Con	rection					Correction					Correction
		Cor	npleted					Completed					Completed
ID Prefix	21610	08/1	12/2015	II	D Prefix	21942		05/15/2015		ID Prefix			-
•	MN Rule 4658.1340 St	ıbp. 1			•	MN St. Statute 144A	.10 Sul	od. {		Reg. #			-
LSC					LSC					LSC			
		Cor	rection					Correction					Correction
			npleted					Completed					Completed
ID Prefix				II	D Prefix					ID Prefix			-
Reg. #					Reg. #					Reg. #			
LSC					LSC					LSC			
Reviewed By	Reviev	ved By		Date):	Signature of	Surve	vor:				Date:	
State Agency	GL/	mm		08	/21/20				3937	,			2/2015
Reviewed By	Review	ved By		Date	:	Signature of	Surve					Date:	
Followup to Survey Completed on: 5/14/2015									a Summary of to the Facility?	YES	NO		
STATE FORM: REVISIT REPORT (5/99)		1		Page 1 of 1					Event ID:	GWJG12	-		

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SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier	Number	Pro	vider/Supplie	r Name				
245606		LAF	KE MINNETONKA	CARE CENTER				
ype of Survey (sele			A Complaint B Dumping In C Federal Mo D Follow-up A Routine/St	vestigation nitoring Visit	F Inspec G Valida H Life s	tion of Car tion afety Code	e J Sano	certification ction/Hearing ce License
A			B Extended S C Partial Ex D Other Surv	tended Surve	_	care facil	ity)	
			SURVEY TEAM A					
lease enter the wor Surveyor Id Number (A)	kload informa 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)		Off-Site Report Preparation Hours (I)
Team Leader 1. 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.								
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10.								
		1					<u> </u>	
otal Supervisory Re	wiew Hours							1.00
otal Clerical/Data								

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

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing the burden, to Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

		1									
Provider/Supplier 245606	Number		ovider/Supplie KE MINNETONKA								
Type of Survey (sele			A Complaint B Dumping In C Federal Mc D Follow-up	vestigation nitoring	F Inspec G Valida	tion of Car	K State License				
Extent of Survey (Se	lect all that	apply):	A Routine/St B Extended S C Partial Ex D Other Surv	Survey (HHA o	r long term		ity)				
			SURVEY TEAM A	ND WORKLOAD	DATA						
Please enter the wor			-	Use the sur	_			-			
Surveyor Id Number (A)	Arrived Departed		Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel (H)	Off-Site Report Preparation Hours (I)			
Team Leader 1. 28120	07/28/2015	07/28/2015	0.25	0.00	0.00	0.00	0.00	0.25			
2.											
3.											
4.											
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9.											
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otal Supervisory Re								0.00			
Was Statement of Def	iciencies give	en to the pr	ovider on-sit	e at complet:	ion of the s	survev?					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					AND TRANSMITTAL TE SURVEY AGENCY			GWJG ility ID: 00234
MEDICARE/MEDICAID PROVI (L1) 245606 STATE VENDOR OR MEDICAID (L2) 519842900		3. NAME AND AI (L3) LAKE MIN (L4) 20395 SUM (L5) DEEPHAVE	NETONKA CA MERVILLE R	ARE CEN	TER (L6) 55331	1. Initi 3. Tern 5. Valid	nination	2 (L8) 2. Recertification 4. CHOW 6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE O (L9)		7. PROVIDER/SU	JPPLIER CATEG	ORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA		Survey After Co	
6. DATE OF SURVEY 05/8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L14/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE		EAR ENDING	DATE: (L35)
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(L37) 21 (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY RE	MARKS (IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):				
See Attached Remarks								
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENC	Y APPROVAL		Date:
Elizabeth Nelson, H	IFE NEII	0	07/24/2015	(L19)	Mark Weath	, Enforceme	ent Specialist	07/28/2015 (L20
P	ART II - TO BE (COMPLETED I	BY HCFA RE	EGIONA	L OFFICE OR SINGLE	STATE AG	ENCY	
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OF PARTICIPATION 07/02/1992	BEGINNING	DATE	ENDING DA	ГЕ	VOLUNTARY 01-Merger, Closure	00_	INVOLUNTA 05-Fail to Mee	<u>aRY</u> et Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbur		06-Fail to Mee	et Agreement
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(== '/	B. Rescind Su	spension Date:	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS			
		03001						
	(L28)	•		(L31)				
1. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE								

(L33)

DETERMINATION APPROVAL

(L32)

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: GWJG Facility ID: 00234

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.



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;

Lake Minnetonka Care Center June 3, 2015 Page 2

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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.

Lake Minnetonka Care Center June 3, 2015 Page 3

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.

Lake Minnetonka Care Center June 3, 2015 Page 4

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

Lake Minnetonka Care Center June 3, 2015 Page 5 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_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 Weath

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

PRINTED: 06/02/2015 FORM APPROVED OMB NO. 0938-0391

T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l					E SURVEY PLETED
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	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L INITIAL COMMENT The facility's plan of as your allegation of Department's acceptotom of the first period be used as verificated. Upon receipt of an revisit of your facility that substantial conhas been attained inverification. 483.15(b) SELF-DEMAKE CHOICES The resident has the schedules, and heather interests, assessinteract with member inside and outside the about aspects of his are significant to the facility failed to dever for ongoing identification preferences related (R1, R22) reviewed. Findings include: R1 stated in an interallation and interallation in the although he had a sepreference would here.	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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 AND PLAN C	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245606	B. WING			05/	14/2015
	PROVIDER OR SUPPLIER	ENTER		20	REET ADDRESS, CITY, STATE, ZIP CODE 395 SUMMERVILLE ROAD EEPHAVEN, MN 55331		
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F 242	staff, nor had he be twice a week was or R1's quarterly Minit 3/16/15, identified I mobility, transferrin hygiene/bathing wit bath schedule indic shower two days a on 12/28/13, identification performance deficit decision-making. It showering indicate independently, but completion, thorough R22 stated in an informed the staff, staff if bathing twice informed the staff, staff if bathing twice her opinion. R22 had been received of the bath is scheduled for a shot temporary care platimited physical moduring an interview director of nursing independent" in bathan a problem if he war week. The DON for unaware R1 or R22 said the facility didupon admission or	een asked by staff if bathing okay with him. mum Data Set (MDS) dated R1 was independent in bed g, walking and personal th set up only. Review of the sated R1 was scheduled for a week. R1's care plan revised fied an ADL self-care related to cognitive loss/poor atterventions for bathing and d resident was able to shower was supervised for	F 2	442			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER NNETONKA CARE CI	ENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 0395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	development of goathe use of high risk laxatives, insulin, a anticholinergic (dry) R7's current physic revealed an order f which are known to (a class of drugs th neurotransmitter achelp to block involumuscles associated Artane (trihexypherextrapyramidyl side (oxybutynin) 5 mg to incontinence; and 3 mg every day for Eside effects of anticmouth, blurred visic sedation, hallucinated difficulty urinating, decreased sweatin increased risk for fraction and monitoring R7's care plan revisitentify use and risuse, and monitoring R7 was also prescribed for constipation; Seand Miralax one care everyday. The care failed to identify R7 medication use, monitorions to decreased to decrease interventions to decrease interventions to decrease insurance care failed to identify R7 medication use, monitorions to decrease insurance care failed to identify R7 medication use, monitorions to decrease insurance care failed to identify R7 medication use, monitorions to decrease insurance care failed to identify R7 medication use, monitorions to decrease insurance care failed to identify R7 medication use, monitorions to decrease insurance care failed to identify R7 medication use, monitorions to decrease insurance care failed to identify R7 medication use, monitorions to decrease care failed to identify R7 medication use, monitorions to decrease care failed to identify R7 medication use, monitorions to decrease care failed to identify R7 medication use, monitorions to decrease care failed to identify R7 medication use, monitorions failed to identify R7 medication use, monitorions to decrease care failed to identify R7 medication use, monitorions failed to identify R7 medication use, monitori	sed 11/29/13, did include the als and interventions related to medications including and those with known ing) side effects. ian orders dated 4/10/15, or the following medications have an anticholinergic effect at block the action of the setylcholine in the brain and antary movements of the d with certain diseases): 1) a) 5 milligrams (mg) daily for effects (EPSE); 2) Ditropan wice daily for urinary 3) Symetrel (amantiadine) 100 PSE. The potential significant cholinergic's included: dry on, constipation, drowsiness, tions, memory impairment, confusion, delirium, g and saliva, causing alls and constipation. However, sed on 11/29/13, failed to k of anticholinergic medication	F2	279	in which all care plans will be monitored monthly to ensure the they are kept current. The DON be responsible for monitoring the schedule and reviewing for compliance with the care plan policy.	l will	

AND DIAN OF CODDECTION IN IMPED:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		245606	B. WING			05/	14/2015
	PROVIDER OR SUPPLIER			203	EET ADDRESS, CITY, STATE, ZIP CODE 95 SUMMERVILLE ROAD EPHAVEN, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 279	R7 was also prescinsulin dependent acting insulin) threscale based on blo (long acting insulin revised 11/29/13, it therapeutic low copotassium diet, ho 11/29/13, did not in hypoglycemic and related to use of incontrol. R7 was also prescing twice daily for plan revised on 11, had bladder inconticileting habits, how the monitoring of etapering or discont R7's quarterly Min 2/11/15, indicated incontinent of urine week) and had no R4's care plan did limitations in range or minimize the ris R4 was observed have contractures without splint device following day R4 w 7:45 a.m. while total nursing assistan R4's care plan data	ribed the following insulin for diabetes mellitus: Novolog (fast e time daily and per sliding ood glucose level and Lantus) at bedtime. The care plan dentified R7 was prescribed a ncentrated sugar and low wever, the care plan revised on dentify the R7's risk for hyperglycemic incidents sulin and goal for glucose ribed oxybutynin (Ditropan) 5 urinary incontinence. The care /29/13, indicated the resident tinence related to improper wever, a plan was lacking for efficacy of drug or potential tinuation of the medication. Imum Data Set (MDS) dated R7 was occasionally a (less than seven times a toileting plan. not address resident's of motion and plan to maintain k for further decline. on 5/12/15, at 3:14 p.m. to of both hands and knees ces and/or braces. The vas observed at breakfast at ally assisted with breakfast by	F2	279			

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		PLETED
		245606	B. WING	;		05/1	14/2015
	PROVIDER OR SUPPLIER	ENTER		:	STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE	(X5) COMPLETION DATE
F 279	bearing) and total of performance. The is use the mechanical bed to wheelchair a wheelchair to/from transportation vehicidentified a ADL fur dressing and persodependence on staplan interventions we eating/nutrition reviset up and serve a resident and provides swallowing /chokin address R4's limitar plan to maintain or range of motion. In an interview with p.m. stated no ROI to R4, and the care limitation in ROM of further decline in rate and the care infections. R4 dated 4/6/15, includent infections. R4 dated 4/6/15, includent in the care psychotropic druginsomnia, use of mechanical services and the care psychotropic druginsomnia, use of mechanical services and to to the care psychotropic druginsomnia, use of mechanical services and to to the care psychotropic druginsomnia, use of mechanical services and to to the care psychotropic druginsomnia, use of mechanical services and to to the care psychotropic druginsomnia, use of mechanical services and the care psychotropic druginsomnia, use of mechanical services and the care psychotropic druginsomnia, use of mechanical services and the care psychotropic druginsomnia, use of mechanical services and the care psychotropic druginsomnia, use of mechanical services and the care psychotropic druginsomnia, use of mechanical services and the care psychotropic druginsomnia, use of mechanical services and the care psychotropic druginsomnia, use of mechanical services and the care psychotropic druginsomnia, use of mechanical services and the care psychotropic druginsomnia, use of mechanical services and the care psychotropic druginsomnia, use of mechanical services and the care psychotropic druginsomnia, use of mechanical services and the care psychotropic druginsomnia, use of mechanical services and the care psychotropic drugins and the car	and locomotion (non-weight dependence on staff for interventions directed staff to all lift for all transfers to/from and to propel resident in room to day room, deck, cle. The care plan also actional problem related to onal hygiene related to total aff for performance. The care under the area of ised 11/1/13, directed staff to all meals and staff to feed the 1:1 supervision for g. The care plan did not ation in range of motion and prevent further decline in the DON on 5/14/15, at 3:28 M was currently being provided to plan did not include R4's or plan to maintain or prevent ange of motion. In the did not address insomnia and cal interventions to promote medication to prevention urinary the surrent physician orders ded an order for Trazodone mmonly prescribed for the bedtime. The medication was minia, and was initiated prior to olan revised 11/1/13, identified however did not address		279			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245606	B. WING			05/1	4/2015	
	PROVIDER OR SUPPLIER	ENTER	STREET ADDRESS, CITY, STATE, ZIP C 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 279	acknowledged the use of the Trazodo interventions to propose R4's current physic included an order of 250 mg take one for three days of the new R4's care plan revision with the first three days of the new and propose to the resident's care plan did not do nor was the use of in the resident's care plan did not was the use of in the resident's care plan did not do nor was the use of in the resident's care plan did urinary tract infection 5/14, and prior to the first three days DON acknowledge the use of the cepton R1's care plan did preferences relate on 5/12/15 at 9:01 R1, resident stated practical nurse or medication to him R1 further indicates	a DON on 5/14/15, at 3:04 p.m. care plan did not include the ne, nor non-pharmacological omote sleep. Sian orders dated 4/6/15, or cephalexin (antibiotic) cap our times a day for the 1st nonths for urinary tract infection hich was started on 9/17/14. sed 11/3/13, identified a ADL ving) functional problem risk of urinary incontinence to on staff for performance. The irect staff to monitor for UTIs, prophylactic antibiotic included re plan. View with DON on 5/14/15, at cated R4 had a history of ons, with the last infection in that in 10/13. The DON cation was reduced from being e first 10 days of the month to of the month on 6/13. The ed the care plan did not include nalexin. not address resident's d to medication delivery. a.m. during an interview with that a staff person (licensed LPN-A) administered that "messes up" his stomach. d the nurse that the that day "does not give medication	F 2	279				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245606	B. WING			05/1	4/2015	
	PROVIDER OR SUPPLIER			20	REET ADDRESS, CITY, STATE, ZIP CODE 1395 SUMMERVILLE ROAD EEPHAVEN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 279	R1's quarterly MDS was cognitively implication of schized R1's integrated profollowing: 1) On 10 that NA had found garbage in the day were found in the garbage in mon-compliant with had seen the physical take meds from expense in medication] estated that he wor anyone working exaccept from nurse placed to [physicial psychologist to infipm/eve [evening] in R1's care plan revision related to impaired long standing mer schizophrenia). In	S dated 3/16/15, indicated R1 paired and identified a ophrenia. Ogress notes revealed the 1/9/14 Informed by night nurse resident's medication in the roomInformed him they garbage and did he know how don't'res [resident] kept ck every few minutes stating stomach." 2) On 10/22/14 the direporting he had received the resident regarding stomach enot new to him. The informed the resident had been in taking his medications, and sician twice that month. 3) On sman heretold him would not rening/noc [night] nurses, he putting poison on his meds and hingested ben gay [topical arlier this year. Resident again all ont accept meds from rening, noc shift but would sthat work during day. Call an]. 5) On 10/30/14 Call to form of not taking meds from	F 2	279				
		nclude the need to schedule essible during the day shift to						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		CONSTRUCTION		COMI	PLETED
		245606	B. WING			_	05/1	14/2015
	PROVIDER OR SUPPLIER	ENTER		20	REET ADDRESS, CITY, STA 395 SUMMERVILLE ROA EEPHAVEN, MN 55331	\D		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVI CROSS-REFERENCE		BE	(X5) COMPLETION DATE
F 282 SS=D	p.m. she explained fewer than six mon care plans "are a p she was prioritizing planned to review a not found the time 483.20(k)(3)(ii) SE PERSONS/PER C. The services proviem ust be provided accordance with eacare. This REQUIREME by: Based on observative review, the facility monitoring for pote antipsychotic medi residents reviewed Findings include: R4's current physic dated 3/17/15, for for paranoid psychomy twice daily on 41/3/12, identified psychotropic medi directed staff to obside effects and residents reviewed side effects and residents reviewed by the service of the service o	oliance with taking If the DON, on 5/14/15, at 4:53 If she had been at the facility Iths, but was aware resident Iroblem." The DON explained If work and although she had Ithe resident care plans, had Ito do so. IRVICES BY QUALIFIED IN ARE PLAN IN IT IS NOT THE PL	F.	279	F-282 A current DISCUS for R4. A Policy a be developed for no current DISCUS for them. Current be evaluations will be MDS due for a result have their care plain indentify what psyside effects to most these to the reside R10 will have their to identify what siresident should be schedule for conductional blood pressure test already been develeffect. A policy blood pressures we DON will be response overseeing the conduction of the policy of the pol	S will be cond and schedule was naintaining a for residents in DISCUS e checked with sident. R4 with revised to exchotropic drantor for and a cont's physician are plan revide effects the emonitored for ucting Orthosts on resident loped and is in for Orthostativill be written consible for mpletion of the cons on the resident and the constant of the	will n need n each ll ug report n. vised or. A tatic ts has n c The	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245606	B. WING _		05	5/14/2015	
	PROVIDER OR SUPPLIER NNETONKA CARE C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 282	primary medical ph (as needed) for effi pharmacist review every month. R4's record revealed being completed or assessments were interview with the Dindicated she was assessment since. R10's current physical revealed an order for medication) 9 mg disorder and bipolar the care plan identificated to bipolar didirected staff to admedications as ord side effects and effications of psychotropic medications of psychotropic medications of psychotropic medication, blurred vicinsomnia, loss of a cramps, nausea, wo not usual to the perpsychotropic medications efficacy, dosage, a evaluate psychotropic medications efficacy.	ysician every 60 days or PRN cacy and side effects and of psychotropic medications ed DISCUS was dated as a 12/29/07. No further TD found in the record. In an 20N on 5/14/15, at 3:04 p.m. unable to find any DISCUS	F 28	82			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245606	B. WING			05/	14/2015
LAKE MI	PROVIDER OR SUPPLIER NNETONKA CARE CI	ENTER TEMENT OF DEFICIENCIES	ID	20	TREET ADDRESS, CITY, STATE, ZIP CODE 0395 SUMMERVILLE ROAD EEPHAVEN, MN 55331 PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	COMPLETION DATE
F 282	Continued From pa	ge 10	F 2	82		-3-15	
F 318 SS=D	pressure monitoring medication use. Re no orthostatic blood completed in last 1' revealed a DISCUS In an interview with p.m. stated she was documentation in thorthostatic blood pr side effects was do she would call the a an assessment was When questioned re is assessed for TD to check our policy, year." No further in including a related 483.25(e)(2) INCRE IN RANGE OF MOOBased on the compresident, the facility with a limited range appropriate treatmer range of motion and decrease in range of	ne record to indicate essures or assessment for TD ne. The DON further stated attending psychiatrist to see if is done recently by psychiatrist egarding how often a resident the DON stated "I would have but would guess once a formation was provided, policy. EASE/PREVENT DECREASE TION Trehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further of motion.	F3	318	An Occupational Therapy combas been ordered for R4 to deve ROM plan for the resident to retheir risk for worsening of contractures. Any Resident not have a decrease in ADL capabil during the completion of their will be assessed for the need for ROM effective immediately. A policy will be developed to ide those resident's who have the potential to develop contracture Any new or worsening of contractures will be noted in the Quarterly QA meetings. The I will be responsible for develop and implementing the policy are ensuring that ROM for all residis assessed timely.	elop a educe eted to lities MDS r A ntify es. e DON ing	
	by: Based on observa review, the facility f rehabilitative service	NT is not met as evidenced tion, interview and document ailed to provide nursing es to maintain or improve OM) for 1 of 1 resident (R4)					

DENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED		
	245606	B. WING		05/14/2015	
NAME OF PROVIDER OR SUPPLIER LAKE MINNETONKA CARE CEI	NTER	20	REET ADDRESS, CITY, STATE, ZIP CODE 1395 SUMMERVILLE ROAD EEPHAVEN, MN 55331		
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLÉTIC	
have contractures of without splint devices following day R4 was 7:45 a.m. while totall a nursing assistant (I of 5/13/15, at 1:12 p. from her wheelchair lift. NA-A then assists side to remove the mand said she did not exercises to R4. NA-not been instructed the for R4 and further stabraces or splints. In an interview with the on 5/11/15, at 5:22 phenomenates of both DON further stated Fexercises in the past R4's quarterly Minimal 4/28/15, included dishemiplegia (paralysis). The MDS indicated I was unable to walk, assistance with activant had a ROM imp	in 5/12/15, at 3:14 p.m. to both hands and knees is and/or braces. The is observed at breakfast at ly assisted with breakfast by NA)-A. During the afternoon it. NA-A transferred R4 to bed using a mechanical ed R4 in turning from side in the inechanical lift transfer sheet. It is done any range of motion it. A further explained she had to complete ROM exercises atted R4 did not utilize any it. She is the inexplained she had knees, hands and hips. The R4 had "refused" ROM it.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		245606	B. WING			05/	14/2015
	PROVIDER OR SUPPLIER NNETONKA CARE CI	ENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 0395 SUMMERVILLE ROAD EEPHAVEN, MN 55331	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 318	indicated "Resident arms, wrists, fingers requires extensive atotal assist with trarunit, dressing, eatin bathing." R4's care plan reviewas totally depende intervention directe for all transfers and from destinations. In a follow up intervat 3:28 p.m. stated conversation with Fithey indicated if the they would pay for therapy evaluation. attempted to approhad refused, but stagain." DON review unable to find any owith R4 or her famino ROM was curred. A policy was requestable to find any owith R4 or her famino ROM was curred. A policy was requestable to find any owith R4 or her famino ROM was curred. A policy was requestable to find any owith R4 or her famino ROM was curred. A policy was requestable to find any owith R4 or her famino ROM was curred. A policy was requestable to find any owith R4 or her famino ROM was curred. A policy was requestable to find any owith R4 or her famino ROM was curred. A policy was requestable to find any owith R4 or her famino ROM was curred. A policy was requestable to find any owith R4 or her famino ROM was curred. A policy was requestable to find any owith R4 or her famino ROM was curred. A policy was requestable to find any owith R4 or her famino ROM was curred. A policy was requestable to find any owith R4 or her famino ROM was curred. A policy was requestable to find any owith R4 or her famino ROM was curred.	has contracture's of her is and legs Resident assist with bed mobility and insfers, locomotion on/off the ig, toileting, grooming and ewed 11/3/12, indicated R4 ent on staff in ADLs. The id staff to use mechanical lift to propel wheelchair to and eight with the DON on 5/14/15, she had a previous R4's family in 3/15 or 4/15, and is DON could "talk mom into it," occupational or physical Although the DON had each the resident about it, she ated, "I should talk to her wed R4's chart and was documentation of conversation ly. The DON further indicated intly being provided to R4. Sted but not provided. EGIMEN IS FREE FROM	F3		The skilled, psychiatric care if the staff at the facility helps is monitor the side effects of antipsychotic medications, we closely with the residents and outside care providers to minit these effects. To ensure that resident does not receive any unnecessary medication with proper monitoring, indication or duration and in the present adverse events, the consultant pharmacist will review the medications of each resident of monthly basis. The consultant pharmacist will make recommendations and request documentation of facility staff prescribers in order to ensure proper documentation for the resident's need for the medical obtained and to start antipsys medication therapy and/or refor gradual dosage reductions these medications, unless clinically contraindicated. For residents R4, R7, R9 and (and all residents in need) a vice of the medical of the residents R4, R7, R9 and (and all residents in need) a vice of the medical of the residents R4, R7, R9 and (and all residents in need) a vice of the medical of the residents R4, R7, R9 and (and all residents in need) a vice of the residents R4, R7, R9 and (and all residents in need) a vice of the residents in need in	orking I their imize a out , dosage ce of t on a nt t ff and e that e ntion is chotic quests of	

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245606	B. WING		05/1	4/2015	
	PROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331	1 0071	4/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 329	resident, the facility who have not used given these drugs therapy is necessa as diagnosed and crecord; and resider drugs receive gradubehavioral interven	•	F 329	form requesting documentation regarding an attempt to reduce dosages of the antipsychotic medications or rationale as to reduction would be detriment the care will be written and less facility for the prescribers to and complete. This will be do the next consultant pharmacis review during the month of Ju 2015. The pharmacy consultate follow up with any prescribe does not complete the form.	why a cal to eft at the view one with st une ant will		
	by: Based on observareview, the facility for side effect of antipsensure efficacy of sedocumented for 4 coresidents reviewed Findings include: R9 was prescribed 50 mg daily since 8 lacked evidence of nine months for the pressure monitoring pressure with position sitting up from a antipsychotic use.	NT is not met as evidenced tion, interview and document ailed to monitor for potential sychotic medication and/or to sleep medication was of 5 (R9, R7, R4, R10) for unnecessary medications. The antipsychotic, clozapine 3/4/14. R9's record, however, monitoring in the previous potential for orthostatic blood of (a sudden drop in blood ion change, such as standing lying position) related to The annual Minimum Data Set 15, revealed the resident		A request will be made for ear resident's prescriber to evaluate possible side effects of the prescribed antipsychotic med (specifically R7 & R9 & R10 prescribers will be requested report on the potential causal incidents of orthostatic blood pressure due to the antipsych medications prescribed for the patient. R7's prescriber will asked to clarify the correct in when use of an "as needed" antipsychotic medication is the warranted, i.e. target behavior prescriber will be	lications 's to notic eir be cidents		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245606	B. WING			05/1	4/2015	
NAME OF PROVIDER OR SUPPLIER LAKE MINNETONKA CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 329	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 TDneurological 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.		F3	329	asked to clarify & justify the ne and be requested to have a trial dosage reduction attempt for th currently used sleep aid. This w done at the monthly consultant pharmacist review during the m	e vill be		
					of June 2015. While the facility has engaged a consultant in the past, the facil will engage the services of some to conduct the Tardive Dyskine monitoring (DISCUS evaluation That individual will be response)	ity eone esia ns).		
	revealed an order f (mg) as needed ev The medication wa attending psychiatr The Medication Ad indicated R7 was a follows during the part of the part	ministration Record (MAR) administered Seroquel as previous four months: stered seven times for c/o complaints of aviation one time equest one time stered three times "res c/o ss, sadness" and crying." tered one times for "yelling, earing." tered three times for "anxiety" to of three times administered.			for completing these evaluation. The DON will be responsible f monitoring the implementation these protocol.	or		
		S dated 2/11/15, indicated the tively intact, and was						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245606	B. WING			05/	14/2015	
NAME OF PROVIDER OR SUPPLIER LAKE MINNETONKA CARE CENTER				20	REET ADDRESS, CITY, STATE, ZIP CODE 395 SUMMERVILLE ROAD EEPHAVEN, MN 55331	•		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 329	independent in bed walking in room, and the room. Diagnos hypertension, diabed depression and Parindicated R7 shower and exhibited no bed taken antidepressa medication daily for assessment period. The care plan dated having potential the aggressive (yelling, slamming doors) rediffectives, ineffective of impulse control more redirections/correct getting enough attestatement was, "resungry outburst per staff to administer rediffectiveness. The utilizing psychotrop Cymbalta, divalproseneded) related to depression and and directed staff to admedications as ord side effects and eff with pharmacy and primary medical phefficacy, side effect applicable, educater risks, benefits and symptoms of psychmonitor/document/finaler.	mobility, transferring and d with supervision outside of es on the MDS included etes, schizophrenia, anxiety, kinson's disease. The MDS et minimal signs of depression ehavioral problems. R7 had ent and antipsychotic the last seven days of the excessive profanity, elated to mental, emotional coping skills, having poor est commonly in response to ion or if she felt she was not ention from others. The goal sident will have no more than 1 week." Interventions directed medications as ordered, for side effects and care plan also identified R7 as ic medications (clozapine, ex ER, and Seroquel as eschizoaffective disorder, kiety. The interventions minister psychotropic ered by physician, monitor for ectiveness every shift, consult psychiatrist every 30 days and ysician every 60 days for s, and dosage reduction if ethe resident/caregivers about the side effects and/or toxic	F3	329				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245606	B. WING		05	/14/2015	
NAME OF PROVIDER OR SUPPLIER LAKE MINNETONKA CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP (20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331	THE RESERVE THE PROPERTY OF THE PARTY OF THE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE	
F 329	effects (shuffling g R7's record reveal blood pressure mode completed in the p Tracking Forms (in experienced the formonths: 1) On 1/11/15, at a without use of wal 2) On 1/18/15, at a independently but 3) On 3/14/15, at a independently in of 4) On 4/11/15, undindependently to b 5) On 4/17/15, at a reported she "fain indicated "knees be R7's record reveal System Condense to diagnose poten having been comp assessments were In addition, R7 was (Ditropan) 5 mg two incontinence, on 2 notes from 6/6/14 for the continued of the benefits outwer side effects.	nesia, extrapyramidyl side pait, rigid muscles, shaking). Iled no evidence of orthostatic pointoring having been previous 11 months. Fall proceeding the process of the pr	F3	329			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		245606	B. WING		05	/14/2015		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 329	program. The care plan reviseresident had bladd improper toileting heresident will be confined interventions of two hours during the incontinence, wake void and monitor four inary tract infection. In an interview with on 5/14/15, at 4:46 unable to find any to indicate orthosts assessments had further stated she psychiatrist to see been completed in about frequency of antipsychotic med would have to che once per year." At R7 was previously (antipsychotic) PR with another medical seroquel was add was unable to local further information assessment. R4's was current princluded an order commonly prescribed time. The medinsomnia, and was medical record lace and the side of	sed on 11/29/13, indicated the er incontinence related to habits. The goal stated "The ntinent during waking hours. directed staff to check every he night and as required for e every two hours at night to or signs and symptoms of on. In the director of nursing (DON) is p.m. she reported she was documentation in R7's record atic blood pressures or TD been completed. The DON would call the attending if an assessment had recently their office. When questioned if testing for TD for a resident on ication the DON stated, "I ck our policy, but would guess at 449 p.m. the DON stated that	F3	329				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		245606	B. WING			05/	14/2015
	PROVIDER OR SUPPLIER NNETONKA CARE CI	ENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	documentation of ninterventions and thinterventions tried passeep aid and monificate determine the effect medication. In additing a distribution for greater attempted. During the morning was observed provivith her breakfast. NA-A transferred Fouring a mechanical turning from side silifit transfer sheet. R4's physician progon 4/6/15, 2/215, 12/1/14, progress in generally a little modern and with the progressing of the progressing and silification. R4's quarterly MDS cognitive impairment dementia. The MD symptoms of feeling and utilizing a antidiover the last seven period. R4's Night Shift Modern and Company of the symptoms of feeling and utilizing a antidiover the last seven period.	tors for sleep disturbance, on-pharmacological ne effectiveness of prior to the initiation of the toring of hours of sleep to stiveness of the the sleep aid tion, no attempt at a dose or than 11 months was of 5/13/15, at 7:45 a.m. NA-A iding total assistance to R4 In the afternoon at 1:12 p.m. R4 from her wheelchair to bed of lift. NA-A then assisted R4 in the to remove the mechanical gress notes, revealed a note 2/1/14 "Sleeping well." Also on note indicated "Overall feels are fatigued than in the past." hiatrist/physician progress documentation to justify the ction and continued need of S also identified mood g tired or having little energy, repressant medication daily days of the assessment	F3	329			
		of Sleep Pattern, had a check rough" and hand written note					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245606	B. WING			05/	14/2015
	PROVIDER OR SUPPLIE			20	REET ADDRESS, CITY, STATE, ZIP CODE 395 SUMMERVILLE ROAD EEPHAVEN, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	In addition, on 12, resident "sleeps to R4's care plan da mood/behavior prodelusions and bei identification of prodecumentation resleep or non-pharutilized to promote the record, no do assessment to idefactors and poten interventions to proder dated 3/17/daily for paranoid to 1 mg twice dail revealed a DISCU further TD assess In an interview wip.m. she verified system for monitor hygiene assessment to ide to 1 mg twice dail revealed a DISCU further TD assess In an interview wip.m. she verified system for monitor hygiene assessmedication to pronursing staff had sheet that contain patterns. The flow through; 2) awake than four hours. The seen discontinued	[hours of sleep] for insomnia." /8/14, it was also noted the		329			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		ONSTRUCTION		E SURVEY PLETED
		245606	B. WING			05/	14/2015
	PROVIDER OR SUPPLIER	ENTER		2039	ET ADDRESS, CITY, STATE, ZIP CODE 5 SUMMERVILLE ROAD PHAVEN, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 329	since 12/29/07 for R10 was observed ambulating indeperresidents sitting in current physician of an order for Invegam daily for obsession bipolar disorder, st R10's quarterly ME resident had no codiagnoses of hyperschizophrenia. The antipsychotic mediseven days during MDS also identified bed mobility, transformedication use, an pressure monitorin previous 11 month not completed. In an interview with p.m. stated she was documentation in torthostatic blood p The DON further sattending psychiation was completed requestioned regardiassessed for TD, to check our policy provided.	on 5/13/15, at 8:15 a.m. Indently and visiting with other dayroom area. The resident's orders signed 4/2/15, revealed a (antipsychotic medication) 9 sive compulsive disorder and parted on 1/8/14. 28 dated 3/29/15, identified the gnitive impairment and had rension, bipolar disease, a resident had utilized cation daily over the previous the assessment period. The di R10 as being independent in	F 3	29			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION		TE SURVEY MPLETED
		245606	B. WING	-		05	/14/2015
	PROVIDER OR SUPPLIER	ENTER		20	TREET ADDRESS, CITY, STATE, ZIP CODE 0395 SUMMERVILLE ROAD EEPHAVEN, MN 55331	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 428 SS=E	The drug regimen of reviewed at least of pharmacist. The pharmacist must the attending physic nursing, and these This REQUIREMENT by: Based on interviewed consultant pharmacist regimens were free medications for 4 or R10) reviewed for use. Findings include: R9 was prescribed 50 mg daily since 8 lacked evidence of nine months for the pressure with position or sitting up from a antipsychotic use. In (MDS) dated 3/15/1 ambulated indepent two falls since the pressure with positions are sitting up from a control of t	of each resident must be note a month by a licensed st report any irregularities to cian, and the director of reports must be acted upon. NT is not met as evidenced and document review, the cist failed to ensure medication from unnecessary for 5 residents (R9, R7, R4, unnecessary mediation use. the antipsychotic, clozapine (1/4/14. R9's record, however, monitoring in the previous potential for orthostatic blood on change, such as standing lying position) related to the annual Minimum Data Set (1/5), revealed the resident dently and had experienced previous assessment period. pharmacist reviews revealed as of drug irregularities over	F	428	The drug regimen review will continue on a monthly basis. Beginning with the June 2015's review requests a gradual dose reductions, requestationale and ay reports of period adverse events caused by a medication therapy will be medication therapy will be medicationally, the phrase, "Not pharmacy concerns" will not by the pharmacy consultant in to minimize any confusion of discounting all previously documented findings. A copy of these recommendation will be left on file in the consumer pharmacist's binder at the fact review by all care providers a simmediate review. The DON will be responsible monitoring the implementation these protocol.	ests for something ade ade allity. The other be used an order for their cortains attended to the order for their error for their error for their sections.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		LE CONSTRUCTION S		E SURVEY IPLETED
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	PROVIDER OR SUPPLIER NNETONKA CARE CI	ENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 428	R7 was prescribed needed (PRN), how were not identified a including orthostatic dyskinesia (or TD-characterized by re long-term use of ce antipsychotics). R7's current physic revealed an order for (mg) as needed every the medication was attending psychiatric. The Medication Adrindicated R7 was a follows during the phoroidal per resident recently five times, and per resident recently for the medication anxiety five times, and per resident recently five times, and per resident recently for the medication anxiety, restlessness "outbursts/anxiety/or 3) In 3/15administ screaming and sweed in 4/15administ as documented two R7's record revealed blood pressure more completed in the promotion of the promotion of the following forms (incompleted in the promotion of the following forms (incompleted in the promotion of the following forms).	the antipsychotic Seroquel as vever, specific target behaviors and potential side effects chypotension and tardive neurological syndrome petitive, involuntary movement rtain drugs, including ian orders dated 4/10/15, or Seroquel 50 milligrams ery four hours for agitation. So ordered on 12/12/14, by the sist. ministration Record (MAR) dministered Seroquel as revious four months: tered seven times for c/o complaints of aviation one time quest one time tered three times "res c/o as, sadness" and crying."	F 4	428			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245606	B. WING _		05	/14/2015
	PROVIDER OR SUPPLIER NNETONKA CARE C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	2) On 1/18/15, at 7: independently but ut 3) On 3/14/15, at 8: independently in da 4) On 4/11/15, unkrindependently to be 5) On 4/17/15, at 7: reported she "fainte indicated "knees but R7's record revealed System Condensed to diagnose potentic having been compliance to diagnose potentic having been compliance from 6/6/14 to for the continued not the benefits outweight of the continued not the	a.45 a.m. fell while ambulating unwitnessed; 100 a.m. fell while ambulating ayroom; 100 a.m. fell while walking ed; 130 a.m. fell to floor, resident ed'" but fall tracking form ackled." 130 a.m. fell to floor, resident ed'" but fall tracking form ackled." 14 d a Dyskinesia Identification of User Scale (DISCUS), used al TD, was dated as last eted in 6/12. No further TD found in the record.	F 42	28		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION G		E SURVEY IPLETED
		245606	B. WING			05/	14/2015
	PROVIDER OR SUPPLIER	ENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331	1 001	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	been completed in about frequency of antipsychotic medic would have to chec once per year." At R7 was previously previous	f an assessment had recently their office. When questioned testing for TD for a resident on cation the DON stated, "I k our policy, but would guess 4:49 p.m. the DON stated that prescribed Haldol I, but was since it interfered ation, it was discontinued and d. The DON indicated she e a related policy, and no was provided related to TD hysician orders dated 4/6/15, or Trazodone (antidepressant ted for insomnia) 50 mg at cation was prescribed for initiated prior to 6/4/14. R4's red evidence of an p patterns, identification of tors for sleep disturbance, on-pharmacological	F	1128	,		
	determine the effect medication. In addit	toring of hours of sleep to tiveness of the the sleep aid tiveness of the the sleep aid tion, no attempt at a dose or than 11 months was					
	on 4/6/15, 2/215, 12 12/1/14, progress n	ress notes, revealed a note 2/1/14 "Sleeping well." Also on ote indicated "Overall feels re fatigued than in the past."					
	notes revealed no d	niatrist/physician progress locumentation to justify the ction and continued need of					

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	PROVIDER OR SUPPLIER NNETONKA CARE CI	ENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 428	under the category mark on "sleeps thr" "Trazodone at HS [I In addition, on 12/8, resident "sleeps thr" R4's integrated prodocumentation relasseep or non-pharm utilized to promote the record, no docu assessment to identactors and potential interventions to prosleep hours to dete was found. The monthly consult 6/30/14 to 4/12/15, of drug irregularities R4's current physic order dated 3/17/15 daily for paranoid pto 1 mg twice daily revealed a DISCUS further TD assessment in an interview with p.m. she verified the system for monitorin hygiene assessment medication to prominursing staff had be sheet that contained	nthly Charting dated 1/1/15, of Sleep Pattern, had a check ough" and hand written note nours of sleep] for insomnia." /14, it was also noted the	F	128			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY PLETED
		245606	B. WING	****		05/	14/2015
	PROVIDER OR SUPPLIER			203	REET ADDRESS, CITY, STATE, ZIP CODE 95 SUMMERVILLE ROAD EPHAVEN, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	through; 2) awake than four hours. The been discontinued was unable to find since 12/29/07 for R10's current physrevealed an order medication) 9 mg of disorder and bipola. The record for R10 blood pressure monitoring previous 11 month not completed. The monthly const 6/30/14 to 4/12/15 of drug irregularities. In an interview with p.m. stated she was documentation in torthostatic blood p. The DON further sattending psychiat was completed requestioned regard assessed for TD, to check our policy provided. Policies provided.	on and off; and 3) sleep less he use of the flow sheet had in 1/15. The DON reported she any DISCUS assessment R4. Sician orders signed 4/2/15, for Invega (antipsychotic daily for obsessive compulsive ar disorder, started on 1/8/14. Diacked evidence of orthostatic positioning related to antipsychotic and no orthostatic blooding had been recorded in the s. In addition, a DISCUS had alltant pharmacist reviews from revealed no recommendations as over past 10 months. In the DON on 5/14/15, at 4:46 as unable to find any the record to indicate pressures or a TD assessment attated she would call the rist to see if an assessment cently by psychiatrist When ing how often a resident was the DON stated "I would have at the DON stated "I would have at the poon in the poon in the poon was were requested but not	F4	-28			
	stated to the surve	proximately 6:00 p.m. LPN-A eyor that the consultant not be available until Monday, orther stated she had the					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			DATE SURVEY COMPLETED	
		245606	B. WING _		05	/14/2015	
	PROVIDER OR SUPPLIER NNETONKA CARE C	ENTER		STREET ADDRESS, CITY, STATI 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 428	surveyor contact in	nge 27 formation and would act information to consultant	F 42	F 431 A new padlock was	6-15-15 placed on the		
	pharmacist. On 5/22/15, at 1:45	p.m. consulted pharmacist		emergency medicate the survey. The em	tion box during nergency		
F 431 SS=F	483.60(b), (d), (e) [unable to be reached. DRUG RECORDS, RUGS & BIOLOGICALS	F 43	attacks all to the motive	rigerator ro moval from the		
	a licensed pharmac of records of receip controlled drugs in accurate reconcilia records are in orde controlled drugs is	nploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug or and that an account of all maintained and periodically		authorized individu access to the medic the nursing staff ha medication box. No gain accces to the k administrator will k			
	labeled in accordar professional princip appropriate access	als used in the facility must be note with currently accepted bles, and include the sory and cautionary e expiration date when		ensuring that this p followed, in keepin policy.			
	facility must store a locked compartme	State and Federal laws, the all drugs and biologicals in into under proper temperature it only authorized personnel to keys.					
·	permanently affixed controlled drugs list Comprehensive Drugs Control Act of 1976 abuse, except whe	rovide separately locked, d compartments for storage of ted in Schedule II of the rug Abuse Prevention and and other drugs subject to an the facility uses single unit ibution systems in which the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245606	B. WING			05/1	4/2015
	PROVIDER OR SUPPLIER	ENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431	Continued From pa quantity stored is m be readily detected	ninimal and a missing dose can	F∠	131			
	by: Based on observa review, the facility to secure medication	NT is not met as evidenced tion, interview, and document ailed to ensure safe and storage of emergency had the potential to affect all facility.					
	Findings include:						
	5/14/15, at 6:58 p.r (LPN)-A informed semergency kit was kitchen area. When entered the kitcher unlocked. LPN-A oremoved the emergency kit including the contract of the padlock on the outer emoved the padlock emergency kit including the contract of the padlock on the padlock or the padlock or the padlock emergency kit including the contract of the padlock or the p	of medication storage, on m. licensed practical nurse surveyor the facility's stored in the refrigerator in the n LPN-A and the surveyor n, the door was found pened the refrigerator and gency kit, which had an open side of the container. LPN-A ck, and the contents of the uded unopened injectable ng insulin, Ativan (antianxiety) sta (antipsychotic).					
	director of nursing that the staff gener shut and sometime stated the emerger been locked with the only staff who have the staf	·					
	A policy was reque	sted but not provided.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION			SURVEY PLETED
		245606	B. WING				05/1	4/2015
	PROVIDER OR SUPPLIER NNETONKA CARE C	ENTER		20	REET ADDRESS, CITY, STATE, ZIP CO 0395 SUMMERVILLE ROAD EEPHAVEN, MN 55331	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 458 F 458 SS=E	483.70(d)(1)(ii) BEIL LEAST 80 SQ FT/F Bedrooms must me per resident in multi least 100 square fet. This REQUIREMEI by: Based on interview facility failed to prospace per resident 104, 205, 206, and affect 12 of 12 resident 104, 205, 206, and affect 12 of 12 resident Romes. Findings include: Resident rooms 10 not meet the requir for multiple resident. The room sizes list administrator on 1/Room 103 had 236 feet per resident Room 205 had 117 feet per resident Room 206 had 138 feet per resident Room 207 had 145 feet per resident.	DROOMS MEASURE AT RESIDENT easure at least 80 square feet ciple resident bedrooms, and at set in single resident rooms. NT is not met as evidenced and document review, the vide 80 square feet of floor as required in rooms 103, 207. That had the potential to dents (R2, R3, R4, R5, R6, R7, R18, R21) who resided in	F 4	1	Waiver Most rooms meet the star guidelines for resident room and the current facility has as a nursing home for overwith no change in the number residents per room. A was renewal will be requested approximately nine (9) squeeded per resident on a veach of these five rooms, see copy of waiver renewant accordance with the particular of each resident and will readversely affect the health of the residents. The room waiver was disclosed to the residents who occupy the the Administrator and signare in their charts. The Administrator presents the size disclosure to future rethe Admission Agreements.	te om sizes oper of siver of the cular reports of t	rated ears of ne eet in se uest need afety opies	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION			E SURVEY PLETED
		245606	B. WING				05/	14/2015
	PROVIDER OR SUPPLIER NNETONKA CARE C	ENTER		20	TREET ADDRESS, CITY, STATE, ZIP C 0395 SUMMERVILLE ROAD EEPHAVEN, MN 55331	ODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 458 F 501 SS=C	hazards and were that was no evidence the impacted by their rebeen informed of the and offered no compute during the survey. On 5/11/15, at 1:30 conference, the adfindings, and stated requested a waiver 483.75(i) RESPON DIRECTOR	furnished adequately. There nese residents were negatively com size. The residents had ne room size prior to admission aplaints regarding their rooms of p.m. during the entrance ministrator verified the above of the facility had previously for the requirement. SIBILITIES OF MEDICAL resignate a physician to serve	F 4		The facility will designate physician to serve as medirector of LMCC. The midirector will be responsible implementation of reside policies and the coordinal medical care in the facility administrator will be responsible recruiting a physician for position of medical direct	e a dical edical ole for ent car ition of ty. The ponsib	: e	
	implementation of recoordination of medical director of practice had the poresidents currently Findings include: During the entrance 1:35 p.m. with the anursing, the admindirector left employ	or is responsible for resident care policies; and the dical care in the facility. NT is not met as evidenced wand document review, the sure a physician served as a the facility. This deficient otential to affect all 21 residing in the facility. The conference on 5/11/15, at administer and director of istrator stated the medical rement with the facility in 11/14. The view on 5/15/15, at 1:20 p.m.						

•	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION			E SURVEY PLETED
		245606	B. WING				05/	14/2015
	PROVIDER OR SUPPLIER			20	TREET ADDRESS, CITY, STATE, ZIF 0395 SUMMERVILLE ROAD EEPHAVEN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROPF	BE	(X5) COMPLETION DATE
F 501	the administrator ex director left the faci has been without a time. The administ	ge 31 kplained that the medical lity on 11/1/14, and the facility medical director since that rator reported they were ling a physician willing to	F 5	501	While the facility cond Quality Assurance mee past year, QA meeting	ucted tw etings in t s will be	the held	
	perform medical dir attempting to get th served in the role fo	ector role and stated he was e previous director who or many years to return.			quarterly in January, Apply October of each year. will have the Medical E Administrator, Director	The facil Director, r of Resid	ity DON, dent	
F 520 SS=C	483.75(o)(1) QAA		F t	520	Services and other LMC as members of the cor Administrator will be r for overseeing the full implementation of this	mmittee. esponsib	The ole	
	assurance committ nursing services; a	tain a quality assessment and ee consisting of the director of physician designated by the 3 other members of the			•			
	committee meets a issues with respect and assurance acti develops and imple	ment and assurance t least quarterly to identify to which quality assessment vities are necessary; and ements appropriate plans of entified quality deficiencies.						
	disclosure of the re except insofar as s	retary may not require cords of such committee uch disclosure is related to the committee with the s section.						
		s by the committee to identify deficiencies will not be used as as.						

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		E SURVEY PLETED
		245606	B. WING	·		05/	14/2015
	PROVIDER OR SUPPLIER	ENTER		2	STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	Continued From particles and assurance (QA required and maintained the potential to in the facility. Findings include: Review of the qualitatendance logs frought the facility QAA con and 10/22/14, and the period of greater meetings and attent which exceeded the need for medical director meetings and attent which exceeded the need for medical director meetings and attent which exceeded the need for medical director meetings and attent which exceeded the need for medical director medical director medical director meetings and attent which exceeded the need for medical director	ANT is not met as evidenced and document review, the sure the quality assessment AA) committee met quarterly as ained required members. This affect all 21 residents residing and 5/1/14 to 5/14/15, identified mittee met twice on 5/25/14 held no meetings in 2015. Or attended the 5/28/14 e 10/22/14 meeting. This was than 11 months between QAA addance by the medical director e quarterly requirement and		520	DEFICIENCY)	NAIL .	
	A policy was reques	sted but not provided.					



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

Lake Minnetonka Care Center June 8, 2015 Page 2

attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - 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.

Lake Minnetonka Care Center June 8, 2015 Page 3 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.

Lake Minnetonka Care Center June 8, 2015 Page 4

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

Lake Minnetonka Care Center June 8, 2015 Page 5 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 Weath

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

5606023

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 01 - MAIN BUILDING 245606 B. WING 06/04/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD **LAKE MINNETONKA CARE CENTER** DEEPHAVEN, MN 55331 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE PICIK KID+39 WIFSES Som KID+39 WIFSES Som KID+39 DEFICIENCY) K 000 | INITIAL COMMENTS K 000 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 .1111 2 2 **2015** CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: MN DEPT. OF PUBLIC SAFET Healthcare Fire Inspections STATE FIRE MARSHAL DIV State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: LABORATORY DIRECTOR'S OR PROVIDER SUPPLIES PRESENTATIVE'S SIGNATURE

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 projection 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.

(X6) DATE

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 11 - MAIN BUILDING	(X3) DATE	SURVEY PLETED
		245606	B. WING			06/	04/2015
LAKE MIN	ROVIDER OR SUPPLIER INETONKA CARE CENTE			20	TREET ADDRESS, CITY, STATE, ZIP CODE 0395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 012 SS=F	1. A description of what to correct the deficient 2. The actual, or proposed 3. The name and/or tit responsible for correct prevent a reoccurrence Lake Minnetonka Care building with a partial I constructed in 1920 at Type V(000) Construct was constructed to the to be of Type V(000). protected. The facility with smoke detection in open to the corridors to department notification capacity of 21 beds with time of the inspection. The requirement at 42 NOT MET as evidence NFPA 101 LIFE SAFE.	ECTION FOR EACH NCLUDE ALL OF THE MATION: at has been, or will be, done cy. beed, completion date. le of the person cion and monitoring to e of the deficiency. Center is a 2-story basement. The building was and was determined to be of tion. In 1960 an addition e north and was determined It is automatic fire sprinkler has a fire alarm system in the corridors and spaces that is monitor for fire in. The facility has a th a census of 19 at the CFR, Subpart 483.70(a)is and by: TY CODE STANDARD ype and height meets one	· KO		To address the K12 Construction Type of Health Care Facilities, FSES has been completed on the facility. Since there were not changes to the building and arwas completed last year, it agwerified that a Two Story Build Type V (000) construction with automatic sprinkler system with meet or exceed the equivalent requirements for the facility. It previous FSESs that have been conducted have verified that the facility has been in compliance the equivalency standards. The have been not alterations, chartor modifications to the building since the last FSES was completed.	a he he he he he he with ere leges g eted.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING	(X3) DATE	SURVEY PLETED
		245606	B. WING			06	/04/2015
	ROVIDER OR SUPPLIER INETONKA CARE CENTE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
K 012	Based on observation does not meet the requirement of type and height. This deficient practice Findings include: On facility tour between on 06/04/2015, observed 2-story, wood frame faconstruction does not construction requirement of the practice of the	not met as evidenced by: n and interview, this building quirement for construction e could affect all residents. en 10:15 AM and 11:15 AM evation revealed that this acility of Type V(000) meet the minimum ents for a building of this	K	012			St.
K 039 SS=F	FSES can establish the level of fire safety equithe Life Safety Code. NFPA 101 LIFE SAFE Width of aisles or corriumobstructed) serving feet. 19.2.3.3 This STANDARD is not Based on observation floor corridor does not	need not be corrected if an at the facility has an overall ivalent to that required by TY CODE STANDARD idors (clear and as exit access is at least 4 of met as evidenced by: and interview, the second meet the minimum 48" s deficient practice could	K	039			

		MEDICAID SERVICES			OMBIN	IO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION 01 - MAIN BUILDING		E SURVEY MPLETED
		245606	B. WING		0	8/04/2045
	ROVIDER OR SUPPLIER	ER		STREET ADDRESS, CITY, STATE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331	, ZIP CODE	6/04/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
K 045 SS=F	and 11:15 AM on 06/0 revealed that portions only 35" wide. This deficient practice administrator via teleprinspection. Note: This deficiency FSES can establish the level of fire safety equates the Life Safety Code. NFPA 101 LIFE SAFE Illumination of means discharge, is arranged lighting fixture (bulb) warkness. (This does	acility between 10:15 AM 04/2015, observation s of the first floor corridor are	K 039	K039 Please see FSES. K 045 The testing of the lighting has been owill be conducted basis. The adminiresponsible for incalong with other tfacility's safety systesting will be doc facility's fire drill radministrator will the ensuring that done on a monthly	done for June and on a monthly strator will be cluding this testing esting of the stems. The umented on the eports. The be responsible for the testing will be	
	Based on observation failed to provide adequaccordance with LSC practice can effect all Findings include: During facility tour bet AM on 06/04/2015, rec	ot met as evidenced by: an and interview, the facility uate emergency lighting in (00) 19.2.8. This deficient residents: ween 10:15 AM and 11:15 cord review revealed that g of the emergency lighting				

	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-039			
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 1 - MAIN BUILDING		E SURVEY IPLETED			
		245606	B. WING_			06	5/04/2015			
NAME OF P	ROVIDER OR SUPPLIER		- 1111	S	TREET ADDRESS, CITY, STATE, ZIP CODE					
LAKE MIN	INETONKA CARE CENTE	- P		21	0395 SUMMERVILLE ROAD					
	TOTAL OF THE OFFICE			D	EEPHAVEN, MN 55331					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 5 Continued From page 4 This deficient practice was verified by the administrator via telephone at the time of the		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE						
K 045	This deficient practice was verified by the		K	045	K062	6-30-15				
K 062 SS=F	inspection. NFPA 101 LIFE SAFE Required automatic specontinuously maintain condition and are insp	TY CODE STANDARD prinkler systems are ed in reliable operating	K	062	The side wall fire sprinkler have been repaired/replaced with appropriate plug by a qualifical licensed personnel. The administrator will be responsensuring that this item is repand/or replaced appropriately	the ed sible for aired				
•	Based on record review has failed to inspect a	ot met as evidenced by: ew and interview, the facility nd maintain the sprinkler with NFPA 13 and NFPA tice could affect the								
	Findings include:				K076 6	-15-15				
	on 06/04/2015, observed a sidewall fire sprinkle and is plumbed into the tank air line T-fitting up	en 10:15 AM and 11:15 AM vation revealed that there is r head in a vertical position e stored water pressure ostream of the check valve.			The two portable liquid oxygitanks have been removed from the nurses station and will not be inside the building. There will storage of liquid oxygen with	en om the e stored II be no				
K 076 SS=F	administrator via telepi inspection.	hone at the time of the	ΚO	76	confines of the facility. The administrator will be responent that no storage of oxy	sible to				
	This deficient practice was verified by the administrator via telephone at the time of the inspection. NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.				tanks is done within the facil	ity.				
	(a) Oxygen storage loc	cations of greater than								

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING	(X3) DATE	SURVEY PLETED
		245606	B. WING	4.1		06	/04/2015
	NNETONKA CARE CENTE SUMMARY STA	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	2	STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331 PROVIDER'S PLAN OF CORRECTION		(X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
K 076			K	076	K147 6- The three extension cords in us rooms 206, 208 and the laundr room have been removed and discontinued. Extension cords not be used within the facility administrator is responsible to that extension cords are not be used in the facility at all.	will The see	
	Based on observation failed to maintain the r	A 99. This deficient practice					
	Findings include:				7.		
	11:15 AM on 06/04/20 that there are (2) portabeing stored at the null						
K 147	This deficient practice administrator via telep inspection. NFPA 101 LIFE SAFE	hone at the time of the	K 1	147			
SS=E		quipment is in accordance al Electrical Code. 9.1.2					
	Based on observation failed to comply with N	ot met as evidenced by: and interview, the facility FPA 70, The National ficient practice could affect					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION 01 - MAIN BUILDING	(X3) DATE	O. 0938-0391 E SURVEY PLETED
		245606	B. WING			06	/04/2015
	ROVIDER OR SUPPLIER INETONKA CARE CENTE			2	STREET ADDRESS, CITY, STATE, ZIP CODE 20395 SUMMERVILLE ROAD DEEPHAVEN, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
K 147	on 06/04/2015, observare extension cords in 206, 208 and the cloth. This deficient practice	en 10:15 AM and 11:15 AM vation revealed that there use in resident room(s) nes washing machine.	К	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 ktags 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

ZONE 01

OF <u>03</u> ZONES

FIRE/SM	OKE ZONE* EVA	ALUATION WO	ORKSHEET I	FOR H	EALTH	I CARE I		FIES FE SAFETY COI
CILITY LAKE MINN	IETONKA CARE	CENTER	BUILDING 01				2000 21	
NE(S) EVALUATED B	BASEMENT							
OVIDER/VENDOR NO	^{D.} 245606		DATE OF SUR	VEY CIV	IS: 6/4/	/2015; FS	SES: 7/9	9/2015
COMPLETE THIS	WORKSHEET FOR T CAN BE USED FC		HERE CONDITI					
Step 1: Determin A. For each	ne Occupancy Risk P Risk Parameter in T Conly one for each of	arameter Factors able 1, select and	- Use Table 1. d circle the appr	opriate	risk facto	or value.		
	TABLE	1. OCCUPANCY	RISK PARAME	ETER F	ACTORS	3		
Risk Parameters		Risk Fa	actors Values					
1. Patient	Mobility Status	Mobile	Limited M	obility	No	t Mobile	No	t Movable
Mobility (M)	Risk Factor	1.0	1.6			3.2		4.5
2. Patient Density (D)	No. of Patients	1–5	6–10			11–30		>30
Denoity (D)	Risk Factor	1.0	1.2			1.5		2.0
3. Zone	Floor	1 81	2 [™] or 3 [™]	4 th to	o 6 ^{lb}	7 th and Ab	ove	Basements
Location (L)	Risk Factor	1.1	1.2	1.	4	1.6	П	1.6
Ratio of Patients to	Patients Attendant	<u>1–2</u> 1	<u>3–5</u> 1	<u>6-</u> 1		> <u>10</u>		One or More None
Attendants (T)	Risk Factor	1.0	1.1	1.	2	1.5		4.0
5. Patient	Age	Under 65 Years	s and Over 1 year		65 Yea	irs and Over	1 Year and	Younger
Average Age (A)	Risk Factor		1.0			1.	2	
A. Transfer	Occupancy Risk Factor the circled risk factor F by multiplying the	values from Table	e 1 to the corre			s in Table 2	es	
	TABLE	2. OCCUPANCY	RISK FACTOR	CALC	JLATION	V		
	OCCUPANCY	RISK 1 x 1	D	т 1 х	A	= 1.60		
A. If building B. Transfer	Adjusted Building St is classified as "NEV the value of F from T R to the block labele	N" use Table 3A. I able 2 to Table 3A	If building is cla A or Table 3B as	approp	oriate. Ca	ng" use Tal alculate R.	ble 3B.	
TABL	E 3A. (NEW BUILDI	NGS)		TABLE	3B. (EX	ISTING BI	UILDING	S)
	1.0 X = R				0.6 X 1	[60] = [1	R	
RE/SMOKE ZONE is a s RVEYOR/SIGNATURE	pace separated from all	other spaces by floo	ors, horizontal exit			rs. DATE		
E AUTHORITY SIGNA	1, When		FIRE TITLE FIRE	MARSH	IAL	DATE	7/09/2	2015
CMS-2786T (06/07) EF 06	110		SUPER	VISOR	2	DATE	7-2	4-15 Pag
ONIO-27001 (U0/U7) EF U6	July 1) Mark							rag

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.

Safety Parameters						Caf	ety Parai	moto-	c \/al	LICC						-
						Said	ety Parai	neter	s vai	ues						_
1. Construction				ombustible s III, IV, and \	′							oustible and II				
Floor or Zone	000			111	20	0	211 -	+ 2HH		000			11 222, 332,		32, 433	3
First	-2			0	-2	2		0		0		2			2	Π
Second	-7	7		-2	-4	.		-2		-2		2			4	_
Third	-9			-7	-6	7		7		-7		2			4	Ξ
4th and Above	-13			-7	-1:	3	19	-7		-9		-7			4	_
2. Interior Finish	Clas	s C		Class	s B		Cla	iss A			-					_
(Corridors and Exits)	-5(0			0(3				3	1							
3. Interior Finish	Clas	s C		Class	· B		Cla	iss A								_
(Rooms)	-3(П	1(3				3	7			1				
4. Corridor	None or In	compl	oto.	<¹/2 h	our		>1/a to	<1 hou			>1 hour	_				-
Partitions/Walls	-10(0	Jui	1		(0) ^a		≥1 hour 2(0) ^a		ĺ				
E Dooro to Corridor			_			Y		, ,	\vdash	- 00 -						_
5. Doors to Corridor	No D	oor		<20 mir	FPR		>20 m	nin FPR		≥20 P	nin FPR a uto Clos.	ilu				
1	-10	0	П	0		V		(O) ^d		2(0) ^d No Dead Ends >30 ft and		Т	i			
6. Zone Dimensions			ш	Dead End		L.		T				d Zone	L ength I	e	-	
O. Zone Dimensions	>100 ft		_	50 ft to 100 f		30 f	t to 50 ft		>150 1		100 ft to			<100 f		-
	-6(0) ^b		1	-4(0) ^b			2(0) ^b		-2(0)°		0	Ī			1 1	
7. Vertical Openings	Open 4 c	or Mor		Open 2	Or 2		2(0)				Indicated	Eiro E	Pociet			-
7. Vertical Openings	Floo			Floo			<1 hr		LIICIC		hr to <2 h		168181.	≥2 hr		-
	-14			-10					1	=	2(0) ^e	П		3(0)°	$-\Gamma$	-
8. Hazardous Areas			ا مار	eficiency		Ч	1		_	eficiency	_(-/	_	N	o Deficie	ncies	-
o. Hazardous Areas	In Zo			Outside	Zone	-	In Zone		igic De		ijacent Zor	16	1	Delicie	10103	
¥ .	-11		П	-5	20110			-6		III / C	-2	ĔΠ		0		7
9. Smoke Control	No Co	_	_	Smoke E	Parriar	_			Acciet	ssisted Systems						-
3. Smoke Control	140 00	JULIOI	_	Serves				IVICCII.								
	-5(0	_{γγ} [1	0		П			3			\Box				
10. Emergency	<2 Rout							M		Routes						-
Movement	VE HOUS						W/O F	Horizont			orizontal					-
Routes				Defici	ent			xit(s)		Horizontai Exit(s)				Direct Ex	kit(s)	
	-8	,]		-2		П		0	7		1	\Box		5	Ť	-
11. Manual Fire Alarm			nual	Fire Alarm		Ч			_	ire Alarm		ш			_	-
The Maria and The Thairm					_		W/O F	D. Cor			F.D. Conn					
			-4	4				1			2	1				
12. Smoke Detection						-				Cor	ridor and	Ť		otal Spa	ces	-
and Alarm	None)		Corridor	Only		Roor	ns Only	,		t. Spaces			In Zone		
	0(3)9	1	П	2(3)	9	П	3	3(3)9	\Box		4	П		5	V	7
13. Automatic	5(5)		Н	Corrido		-		ntire	-			_			1.	-
Sprinklers	None)		Habit. S				ilding								
	0		П	8		П		10	1							
(existing bu	•	· 10 is er than	-8. i 31 p	patients		,	unprote f Use (and ex Param	ected ty) if the cit or roce eter 13	/pe of area oom is piis 0; u	construct f Class B protected se () if t	s based or ion (colum or C inter by automa the room vautomatic	ns m ior fin atic sp vith e sprint	arked " nish in t prinkler xisting	000" or "a ne corrid s and Class C arameter	200") or	

For SI units: 1 ft = 0.3048 m

⁹ 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 1/2 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 S₁, S₂, S₃, S₆ to blocks labeled S₁, S₂, S₃, S₆ 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 (S₄)					
1. Construction	-7	-7		-7					
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					

MANDATORY SA	AFETY REQUIF		LE 6. R USE IN HOSF	PITALS OR NU	JRSING HOMES	5)
	People M (S					
Zone Location	New	Exist.	New	Exist.	New	Exist.
1 st story 2 nd or 3rd story ^b 4 th story or higher	11 15 18	5 9 9	15(12) ^a	4 6	8(5) ^a 10(7) ⁴ 11(8) ⁴	1 3 3 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and Sc 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.

	Yes	No				
Containment Safety (S ₁)	minus	Mandatory Containment (S _a)	≥ 0	$ \begin{bmatrix} S_1 \\ 9 \end{bmatrix} - \begin{bmatrix} S_a \\ 9 \end{bmatrix} = \begin{bmatrix} C \\ 0 \end{bmatrix} $		
Extinguishment Safety (S ₂)	minus	Mandatory Extinguishment (S₀)	≥ 0	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$		
People Movement Safety (S ₃)	minus	Mandatory People Movement (S _c)	≥ 0	$\begin{bmatrix} S_3 \\ 14 \end{bmatrix} - \begin{bmatrix} S_c \\ 3 \end{bmatrix} = \begin{bmatrix} P \\ 11 \end{bmatrix}$	\	
General Safety (S ₄)	minus	Occupancy Risk (R)	≥ 0	$\begin{bmatrix} S_4 \\ 17 \end{bmatrix} - \begin{bmatrix} R \\ 1 \end{bmatrix} = \begin{bmatrix} G \\ 16 \end{bmatrix}$	/	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEE	T			
	omplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met		Not Met	Not Applic.
Α.	Building utilities conform to the requirements of Section 9.1.	1			
В.	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.	1	Į.		
E.	There are no flue-fed incinerators.	1			
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.	1			
G.	Smoking regulations have been adopted and implemented in accordance with 18.7.4 and 19.7.4.	1			i sina
Н.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	1			
Ĵ.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	1			
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	1			
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	1			
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.				\checkmark

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

ZONE 02

OMB No. 0938-024

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

	2000 LIFE SAFETY CODE
FACILITY LAKE MINNETONKA CARE CENTER	BUILDING 01
ZONE(S) EVALUATED FIRST FLOOR	
PROVIDER/VENDOR NO. 245606	DATE OF SURVEY 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	Y RISK PARAM	ETER F	ACTOR	S				
Risk Parameters Risk Factors Values										
1. Patient	Mobility Status	Mobile	Limited N	Nobility	No	t Mobile	Not Movable			
Mobility (M)	Risk Factor	1.0	1.€			3.2	4.5			
2. Patient Density (D)	No. of Patients	1–5	6–1	0		11–30	>30			
Density (D)	Risk Factor 1.0 1.2			1.5	2.0					
3. Zone	Floor	18	2 rd or 3 rd	4 th t	o 6 ^{lh}	7 th and Above	Basements			
Location (L)	Risk Factor	1.1	1.2	1.	.4	1.6	1.6			
Ratio of Patients to	<u>Patients</u> Attendant			<u>10</u> ≥10 1		One or More None				
Attendants (T)	Risk Factor	1.0	1.1	1.	2	1.5	4.0			
5. Patient Average	Age	Under 65 Yea	rs and Over 1 year		65 Years and Over 1 Year and Younger					
Age (A)	Risk Factor		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								
OCCUPANCY RISK	M 3.2 x	D 1.5 X	L 1.1 x	T 1.5 X	A 1.2 =	F 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)	TABLE 3B. (EXISTING BUILDINGS)
1.0 X = R	$0.6 \times 9.50 = 6$

* FIRE/SMOKE ZONE is a space separated from all other spaces b	y floors, horizontal exits, or smoke barrier	s.
SURVEYOR SIGNATURE JULIAN	TITLE DEPUTY STATE FIRE MARSHAL	DATE 7/09/2015
FIRE AUTHORITY SIGNATURE	TITLE FIRE SAFETY SUPERVISOR	DATE 7-24-15
Form CMS-2798T (08/07) \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		Dono 1

- 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.

						TABL													
Safety Parameters						Sat	ety Paran	neter	s Val	ues									
1. Construction	Combustible Types III, IV, and V															Combu es I ai			
Floor or Zone	000			111		200	211 +	2HH		000			111		222, 332	, 433			
First	-2	1		0		-2				0			2		2				
Second	-7			-2		-4	-2	2		-2			2		4				
Third	-9			-7		-9	-			-7			2		4				
4th and Above	-13			-7		-13		7		-9			-7		4				
2. Interior Finish	Cla	ss C	12		Class B		Clas	ss A											
(Corridors and Exits)	-5	(0) ^r			0(3) ¹			3	V										
3. Interior Finish		ıss C			Class B		Clas	ss A											
(Rooms)	-3	3(1) ^f			1(3) ^r		3	3	V										
4. Corridor	None or	Incomp	lete	<	1/2 hour		≥¹/₂ to <	<1 hou	r		≥1 h	our							
Partitions/Walls	-10	0(0) ^a			0		1(0	0)ª	1		2(0)	a	П						
5. Doors to Corridor	No	Door		<20	min FP	'R	≥20 mi	in FPR			min F Auto C	PR ar	nd						
		10			0		1(0	0) _q	1		2(0)	d							
6. Zone Dimensions			_	Dead Er	nd					No Dead	d End	s >30	ft and	Zone L	ength Is				
	>100 ft >				ft to 50 ft		>150	ft	100	ft to	150 ft		<100 ft						
	-6(0) ^t		1	-4(0)b			-2(0) ^b		-2(0)°			0			1	1			
7. Vertical Openings		Open 4 or More Open 2 or 3 Enclosed with Indicated F Floors <1 hr			esist.	≥2 hr													
t t		-14			-10			0 🗸 2(0)°		П		3(0)e	$\neg \Gamma$						
8. Hazardous Areas		Dou	ole D	eficiency		Sir		e Deficiency				No Deficiencies							
	In Zone			Outside Zone			In 2	Zone	.3	In Adjacent Zone		e							
		-11 -5 -6				-5		-6	П		-2		\Box		0	1			
9. Smoke Control	No C	Control			ke Barri ves Zon			Mech. Assisted Systems by Zone											
	-5(0)°			0				3	3			П							
0. Emergency	<2 Ro		-					M	lultiple	Routes									
Movement							W/O H				lorizo	ntal							
Routes				D	eficient		Ex	cit(s)			Exit(s)			Direct Exit	(s)			
		-8			-2	1		0			1		П		5				
1. Manual Fire Alarm		No Ma	anual	Fire Alar	m			Ma	Manual Fire Alarm				_						
							W/O F.	D. Cor	ın.	W	/F.D.	Conn							
				4				1			2		1						
2 Smoke Detection and Alarm	Nor	ie		Corr	ridor On	ly	Room	ns Only	,		rridor it. Šp				ital Space In Zone	s			
	0(3)9	П		2(3) ^g	V	3((3) ⁹	\Box		4		П		5				
3. Automatic Sprinklers	Nor	ne			ridor an oit. Spac			ntire Iding											
Ophinicis I	0				8			10	7										

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

For SI units: 1 ft = 0.3048 m

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.

⁹ 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 S₁, S₂, S₃, S₆ to blocks labeled S₁, S₂, S₃, S₆ 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					
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	S1= 16	S ₂₌ 12	S ₃₌ 10	S ₄₌ 19					

MANDATORY S	AFETY REQUIR		LE 6. R USE IN HOSF	PITALS OR NU	RSING HOMES	S)
	Containment (S ₂)		Extinguishment (S _b)		People Movement (S₀)	
Zone Location	New	Exist.	New	Exist.	New	Exist.
1 st story 2 nd or 3rd story ^b 4 th story or higher	11 ☐ 15 ☐ 18 ☐	5 🗸 9 📉 9 🦳	15(12) ^a 17(14) ^a 19(16) ^a	4 🗸 6 🚞	8(5)ª 10(7)¶ 11(8)¶	1[/] 3[] 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and Sc 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.

	Yes	No				
Containment Safety (S ₁)	minus	Mandatory Containment (S₀)	≥ 0	$\begin{bmatrix} S_1 \\ 16 \end{bmatrix} - \begin{bmatrix} S_a \\ 5 \end{bmatrix} = \begin{bmatrix} C \\ 11 \end{bmatrix}$		
Extinguishment Safety (S ₂)	minus	Mandatory Extinguishment (S₀)	≥ 0	$\begin{bmatrix} S_2 \\ 12 \end{bmatrix} - \begin{bmatrix} S_b \\ 4 \end{bmatrix} = \begin{bmatrix} E \\ 8 \end{bmatrix}$	\	
People Movement Safety (S ₃)	minus	Mandatory People Movement (S₂)	≥ 0	$\begin{bmatrix} S_3 \\ 10 \end{bmatrix} - \begin{bmatrix} S_0 \\ 1 \end{bmatrix} = \begin{bmatrix} P \\ 9 \end{bmatrix}$	✓	
General Safety (S ₄)	minus	Occupancy Risk (R)	≥ 0	$ \begin{array}{c c} S_4 & R & G \\ \hline 19 & - 6 & = 13 \end{array} $	/	

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEE	Т	0	
	mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.
A.	Building utilities conform to the requirements of Section 9.1.	V		
В.	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.	\overline{V}		1 8 S
E,	There are no flue-fed incinerators.	\checkmark		
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.	$\overline{\mathbf{V}}$		
Н,	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	✓		
1.	Fire extinguishers are provided in accordance with the requirements of 18.3.5.4 and 19.3.5.6.	✓		N 1,32 II
J.	Exit signs are provided in accordance with the requirements of 18.2.10.1 and 19.2.10.	\checkmark		
K.	Emergency lighting is provided in accordance with 18.2.9.1 or 19.2.9.	V		
L.	Standpipes are provided in all new high rise buildings as required by 18.4.2.			

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

ZONE 03

ZONES

FIRE/SMOKE ZONE* EVALUATION WORKSHEET FOR HEALTH CARE FACILITIES

	2000 LIFE SAFETY CODE
FACILITY LAKE MINNETONKA CARE CENTER	BUILDING 01
ZONE(S) EVALUATED SECOND FLOOR	
PROVIDER/VENDOR NO. 245606	DATE OF SURVEY 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.

1	TABLE	1. OCCUPANCY	RISK PARAM	ETER F	ACTOR	S								
Risk Parameters		Risk Factors Values												
1. Patient Mobility (M)	Mobility Status	Mobile	Limited M	obility	No	t Mobile	Not Movable							
	Risk Factor	1.0	1.6			3.2	4.5							
2. Patient Density (D)	No. of Patients	1–5	610			11–30	>30							
Defisity (D)	Risk Factor	1.0	1.2	✓		1.5	2.0							
3. Zone	Floor	1 <u>st</u>	2 [™] or 3 [™]	4 ^հ t	o 6 th 7 th and Abo		ve Basements							
Location (L)	Risk Factor	1.1	1.2	1.2 1.		1.6	1.6							
4. Ratio of Patients to	<u>Patients</u> Attendant	<u>1–2</u> 1	<u>3–5</u> 1	<u>6</u>	<u>10</u>	> <u>10</u> 1	One or More None							
Attendants (T)	Risk Factor	1.0	1.1	1.1 1.		1.5	4.0							
5. Patient	Age	Under 65 Yea	rs and Over 1 year		65 Years and Over 1 Year and Younger									
Average Age (A)	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											
OCCUPANCY RISK	М 3.2 х	D 1.2 >	L (1.2)	T x 1.5 x	A 1.2 =	F = 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.

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

TABLE 3A. (NEW BUILDINGS)	TABLE 3B. (EXISTING BUILDINGS)
1.0 X = =	$0.6 \times 8.30 = 5$

The Dollo NE 2011E is a space separated from an other space	so by moore, morreonital exite, or emone parties	.
SURVEYOR SIGNATURE	TITLE DEPUTY STATE FIRE MARSHAL	DATE 7/09/2015
FIRE AUTHORITY SIGNATURE	TITLE FIRE SAFETY SUPERVISOR	DATE 7-24-65
Farm CMC OTRET (DC/DT) FF DC/DDD7		Done 1

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.

						TABL	E 4.																		
Safety Parameters						Sa	fety Par	amet	ers V	alu	es														
1. Construction	Combustible Types III, IV, and V												9												
Floor or Zone	000			111	11 200		200		1 200		1 200		11 200		21	+ 2H	н		000		11	1	222, 3	32, 43	3
First	-2			0	i	-2	\neg	0	П		0	\neg	2		1 :	2									
Second	1-7	1		-2		-4		-2	П		-2		2		1 .	1									
Third	-9			-7		-9		-7			-7		2		1	4									
4th and Above	-13			-7		-13		-7			-9		-7]	4									
Interior Finish (Corridors and Exits)	Clas				ass B D(3) [†]			lass A	- I	7															
3. Interior Finish (Rooms)	Clas				ass B		C	lass A	Τ,	7															
4. Corridor Partitions/Walls	None or Ir		ete	<1/:	hour 0		≥1/2 1	o <1 h	our	7		1 hour 2(0)ª		1											
5. Doors to Corridor	No E	Door		<20 r	nin FP	PR	≥20	min F	PR		≥20 m Au	in FPR													
	-1	0			0			1(0) ^d	V	7		2(0) ^d]											
6. Zone Dimensions				Dead End					-	N	o Dead I	inds >	30 ft a	nd Zon	e Length I	s									
	>100 ft		>	50 ft to 10	0 ft	30	ft to 50 ft		>15	50 ft		100 ft	to 150	ft	<100 f	t	Ξ								
	-6(0) ^b			-4(0) ^b			-2(0) ^b		-2((0)°			0		1	J	/								
7. Vertical Openings	Open 4	or Mor	e	Oper	n 2 or	3	Enclosed with Indicated Fire		d Fire	Resist.															
	Flo	ors		FI	oors			<1 hr		≥1 hr		hr to <2 hr			≥2 hr										
	-1	4			-10			0	v	√ 2		2(0) ^e		3(0)e											
8. Hazardous Areas		Doub	ote D	Deficiency			Single Deficiency			1	No Deficie	ncies													
	In Z	one	_	Outsi	de Zor	ne	Į i	n Zone	, _		In Adja	cent Z	one	е			_								
	-1	1			-5			-6				-2			0	y	_								
9. Smoke Control	No Co	ontrol		4	e Barr es Zon			Me		siste y Zor	d System ne	ıs													
	-5(0)°	✓		0					3															
10. Emergency	<2 Rou	ites							Multip	ole R	loutes						_								
Movement Routes				Det	ficient		W/O Horizont Exit(s)				Horizontal Exit(s)		Direct Exit(s)												
	-8	3	No.		-2	✓		0				1			5										
11. Manual Fire Alarm		No Ma	nual	l Fire Alarm	1	111			Manua	al Fir	e Alarm					1	Ī								
							W/O	F.D. C	onn.		W/F	D. Co	nn _	1											
				4				1				2	✓												
12 Smoke Detection and Alarm	None	e	44.0		dor On	ıly	Ro	oms C	nly			dor and Space			Total Spa In Zone		0								
	0(3)	9		2	(3) ^g		<u> </u>	3(3) ⁹		1		4	✓		5										
13. Automatic Sprinklers	None	9	_		dor an Spac		E	Entire Building																	
	0				8			10																	
NOTE: a Use (0) who b Use (0) who c Use (0) on (existing bu d Use (0) who	ere parameter floor with feword ildings only)	r 10 is er thar	-8. 1 31	patients			unpr f Use and Para interi	otected () if the exit or meter or finis	d type ne area room i 13 is 0 sh is pi	of co a of (is pro); use rotec	onstruction Class B of Stected be () if the	on (colu or C into y auto e roon utomat	umns r terior fi matic s n with o ic sprir	narked nish in sprinkle existing nklers, l	Class C Parameter	200") or									
For SI units: 1 ft = 0.30	048 m				^g Use this value in addition to Parameter 13 if the entire zone is protected with quick-response automatic sprinklers.					s															

- 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 S₁, S₂, S₃, S₆ to blocks labeled S₁, S₂, S₃, S₆ 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 (S4)							
1. Construction	-7	-7		-7							
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	S1= 11	S ₂₌ 9	S ₃₌ 12	S ₄₌ 16							

TABLE 6. MANDATORY SAFETY REQUIREMENTS (FOR USE IN HOSPITALS OR NURSING HOMES)											
		Containment Extinguishment People M (Sa) (Sb) (S									
Zone Location	New	Exist.	New	Exist.	New	Exist.					
1 st story 2 nd or 3rd story ^b 4 th story or higher	11 <u> </u> 15 <u> </u> 18 <u> </u>	5 9 9	15(12) ^a 17(14) ^a 19(16) ^a	4 6 6	8(5)ª 10(7)ª 11(8)ª	1□ 3☑ 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: Sa=7, Sb=10, and Sc=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 Sa, Sb, and So 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									
Containment Safety (S ₁)	minus	Mandatory Containment (S _a)	≥ 0	$\begin{bmatrix} S_1 \\ 11 \end{bmatrix} - \begin{bmatrix} S_a \\ 9 \end{bmatrix} = \begin{bmatrix} C \\ 2 \end{bmatrix}$						
Extinguishment Safety (S ₂)	minus	Mandatory Extinguishment (S₀)	≥ 0	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	\					
People Movement Safety (S ₃)	minus	Mandatory People Movement (S₀)	≥ 0	$\begin{bmatrix} S_3 \\ 12 \end{bmatrix} - \begin{bmatrix} S_c \\ 3 \end{bmatrix} = \begin{bmatrix} P \\ 9 \end{bmatrix}$	\					
General Safety (S ₄)	minus	Occupancy Risk (R)	≥ 0	$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$						

	TABLE 8. FACILITY FIRE SAFETY REQUIREMENTS WORKSHEET								
	mplete one copy of this worksheet for each facility. r each consideration, select and mark the appropriate column.	Met	Not Met	Not Applic.					
A.	Building utilities conform to the requirements of Section 9.1.	√		(31.8)					
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.	V							
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.	$\overline{\mathbf{V}}$							
Н.	Draperies, upholstered furniture, mattresses, furnishings, and decoration combustibility is limited in accordance with 18.7.5 and 19.7.5.	√							
1.	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.	\checkmark							
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.			\checkmark					

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 <i>Life Safety Code.</i> *
 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 <i>Life Safety Code</i> . 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.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0242. The time required to complete this information collection is estimated to average 5 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: PRA Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.



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 <u>only a suggestion</u> 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.

Lake Minnetonka Care Center June 3, 2015 Page 2

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

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00234	B. WING		05/1	4/2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
LAKE MIN	NETONKA CARE CENTE	ER .	MERVILLE RO EN, MN 55331	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEN	TION*****				
	NH LICENSING CO	ORRECTION ORDER				
	144A.10, this correcting pursuant to a survey. found that the deficient herein are not correct not corrected shall be with a schedule of finithe Minnesota Depart. Determination of whe corrected requires correquirements of the runumber and MN Rule When a rule contains comply with any of the lack of compliance. Live-inspection with any result in the assessments.	ther a violation has been				
	that may result from rorders provided that a	earing on any assessments non-compliance with these written request is made to 15 days of receipt of a for non-compliance.				
	this Department's star and the following corr When corrections are date, make a copy of	nd 14, 2015, surveyors of ff, visited the above provider ection orders are issued. completed, please sign and these orders and return the ota Department of Health,		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7 50.125 10.			
		00234	B. WING		05/14/2015	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
LAKE MIN	INETONKA CARE CENT	ER	MMERVILLE RO			
	CLIMMADY CT		/EN, MN 55331		NI 0.5	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
2 000	Continued From page	e 1	2 000			
	Certification P.O. Box 55164-0900.	64900, St. Paul, Minnesota		The assigned tag number appears in far left column entitled "ID Prefix Tag The state statute/rule number and the corresponding text of the state statute 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 whare in violation of the state statute af statement, "This Rule is not met as evidenced by." Following the surveyof findings are the Suggested Method Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADIN THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THE WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STATSTATUTES/RULES.	g." e e/rule " iich ter the ors of HIS	
2 255	MN Rule 4658.0070 Assurance Committe	Quality Assessment and e	2 255			
	of the administrator, the services, the medical designated by the methree other members representing discipling	maintain a quality urance committee consisting the director of nursing director or other physician edical director, and at least of the nursing home's staff, es directly involved in uality assessment and				

Minnesota Department of Health

STATE FORM 6899 GWJG11 If continuation sheet 2 of 37

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
and Plan of Correction identification number:		A. BUILDING: _		COMPLETED		
		00234	B. WING		05/14/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
I AKE MIN	NETONKA CARE CENTE	20395 SUN	MERVILLE RO	DAD		
LAKE WIIN	METONIKA CAKE CENTI	DEEPHAV	EN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
2 255	Continued From page	2	2 255			
	assurance committee respect to which qual necessary and develor appropriate plans of a quality deficiencies. address, at a minimum reporting, infection compharmacy services. This MN Requirement by: Based on interview at facility failed to ensure and assurance (QAA) required and maintain	must identify issues with ity assurance activities are op and implement action to correct identified				
	Findings include:					
	the facility QAA comn	assurance meeting 5/1/14 to 5/14/15, identified nittee met twice on 5/25/14 Id no meetings in 2015.				
	a period of greater that meetings and attenda	10/22/14 meeting. This was an 11 months between QAA ance by the medical director quarterly requirement and				
	administrator explaine six months, but acknown held every six months administrator stated to left the facility on 11/1	1/15/15, at 1:20 p.m. the ed that the QAA met every owledged a meeting was not so over the past year. The he previous medical director 1/14, and the facility had al director since that time.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00234	B. WING		05/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STAT	TE, ZIP CODE	
LAKE MIN	INETONKA CARE CENTE	ER .	IMMERVILLE RO VEN, MN 55331	AD	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
2 255	The administrator or or review, and/or revise ensure the quality assincludes the required quarter to ensure ong administrator or design appropriate staff on the procedures. The admidevelop monitoring sycompliance.	od but not provided. OD OF CORRECTION: designee could develop, policies and procedures to surance (QA) committee members and meets every oing compliance. The linee could educate all	2 255		
2 295	programs. In a nursi one person must be of for coordination of all programs. This MN Requirement by: Based on interview and facility failed to ensure supervisors were edurequired. Findings include: During the entrance of	n of in-service education ng home with over 90 beds, lesignated as responsible in-service education It is not met as evidenced and document review the e direct care staff and cated on dementia care as	2 295		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00234	B. WING		05/14/2015
	ROVIDER OR SUPPLIER	20395 SL	DDRESS, CITY, STAT IMMERVILLE RO VEN, MN 55331	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
2 295	survey from 5/11/15 to During phone call to consider the state of 5/26/15, training documents of the suggested however not suggested however not supervisors. The DO all appropriate staff of procedures to ensure dementia care, and consystems to ensure on the supervisors.	ation was provided during to 5/14/15. lirector of nursing (DON) on mentation was again of provided by facility. OD FOR CORRECTION: g (DON) or designee could for revise training related to ect care staff and N designee could educate in the policies and staff are educated on build develop monitoring	2 295		
2 560	Plan of Care; Contents of comprehensive plan of objectives and timetal long- and short-term of and mental and psychidentified in the comprehensive plan of the comprehensive identified in the comprehensive include the indivirulation of the content include the individual of the content includes the conte	plan of care. The of care must list measurable bles to meet the resident's goals for medical, nursing, nosocial needs that are rehensive resident nprehensive plan of care idual abuse prevention plan a Statutes, section 626.557,	2 560		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(3) DATE SURVEY COMPLETED	
	00234	B. WING		05/	14/2015	
ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE			
INETONKA CARE CENTI	ER .		_			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
Continued From page	e 5	2 560				
reviewed for unneces of motion for 1 of 1 re range of motion; and	sary medications; for range sident (R4) reviewed for to honor medication					
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.						
revealed an order for which are known to h (a class of drugs that neurotransmitter acet help to block involunt muscles associated v Artane (trihexyphen) extrapyramidyl side e (oxybutynin) 5 mg twi incontinence; and 3) mg every day for EPS side effects of antichomouth, blurred vision sedation, hallucinatio difficulty urinating, co decreased sweating a increased risk for falls R7's care plan revise identify use and risk ouse, and monitoring i R7 was also prescrib for constipation; Sent	the following medications ave an anticholinergic effect block the action of the ylcholine in the brain and ary movements of the with certain diseases): 1) 5 milligrams (mg) daily for ffects (EPSE); 2) Ditropan ce daily for urinary Symetrel (amantiadine) 100 SE. The potential significant blinergic's included: dry constipation, drowsiness, ns, memory impairment, infusion, delirium, and saliva, causing and constipation. However, d on 11/29/13, failed to of anticholinergic medication interventions.					
	ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page risk medications for 2 reviewed for unneces of motion for 1 of 1 re range of motion; and preference for 1 of 2 dignity. Findings include: R7's care plan revised development of goals the use of high risk material layers and anticholinergic (drying R7's current physicial revealed an order for which are known to have a capped and the use of high risk material layers and sociated was a continued to the problem of	DEPTIFICATION NUMBER: 00234 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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	ROVIDER OR SUPPLIER RINETONKA CARE CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 5 risk medications for 2 of 5 residents (R7, R4) reviewed for unnecessary medications; 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 medications for constipation; Senna Lax 8.6 mg twice daily and Miralax one capful with juice or water	ROVIDER OR SUPPLIER ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2036 SUMMERVILLE ROAD DEEPHAVEN, MN 55331 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) 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 rignity. 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 neurotransmitter acetylcholine in the brain and help to block involuntary movements of the neurotransmitter acetylcholine in the brain and help to block involuntary movements of the neurotransmitter acetylcholine in the brain and help to block involuntary movements of the neurotransmitter acetylcholine in the brain and help to block involuntary movements of the neurotransmitter acetylcholine in the brain and help to block involuntary movements of the neurotransmitter acetylcholine in the brain and help to block involuntary movements of the neurotransmitter acetylcholine, in the brain and help to block involuntary movements of the neurotransmitter acetylcholine, in the brain and help to block involuntary movements of the neurotransmitter acetylcholine, in the brain and help to block involuntary movements of the neurotransmitter acetylcholine, in the brain and help to block of the secondary of the provide the secondary of the secondary of the secondary of the secondary of th	DECORRECTION DO234 B. WING DO25 ROYLDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JIP CODE 2039S SUMMERVILLE ROAD DEPHAVEN, MN 55331 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES BLOOM DEPHAVEN, MN 55331 SUMMARY STATEMENT OF DEFICIENCIES BLOOM DEPHAVEN, MN 55331 SUMMARY STATEMENT OF DEFICIENCIES BLOOM DEPHAVEN, MN 55331 CACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATION ONLY SIZE BENTIFYING INFORMATION) CONTINUED FROM DEPHAVEN, MN 55331 PROVIDER'S PLAN OF CORRECTION (REACH CORRECTIVE ACTION SHOULD BE PREFIX TAG THE OF THE ORD	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE		
AND PLAN (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMF	PLETED
		00234	B. WING		05	/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
LAKE MIN	INETONKA CARE CENTE	ER	JMMERVILLE RC)AD		
		DEEPHA	VEN, MN 55331			T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 560	Continued From page	e 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.					
	insulin dependent dia acting insulin) three ti scale based on blood (long acting insulin) a revised 11/29/13, ider therapeutic low conce potassium diet, howe 11/29/13, did not ider hypoglycemic and hyp	-				
	mg twice daily for uriplan revised on 11/29 had bladder incontine toileting habits, hower the monitoring of efficiapering or discontinuted R7's quarterly Minimute 2/11/15, indicated R7	ess than seven times a				
	or minimize the risk for R4 was observed on have contractures of without splint devices following day R4 was	motion and plan to maintain or further decline. 5/12/15, at 3:14 p.m. to both hands and knees				

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WIIIIICSOL	a Department of Fleatt		_			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
			1			
			D WING			
		00234	B. WING		05/14/2015	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		20395 SII	MMERVILLE RO	DAD		
LAKE MIN	INETONKA CARE CENTE	ER .	EN, MN 55331			
			LIN, IVIIN 33331	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	(- /	
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPI		
		·		DEFICIENCY)		
0.500		_				
2 560	Continued From page	2 7	2 560			
	a nursing assistant (N	IA)-A				
	a mananing addictant (i.e.	, 7				
	R4's care plan dated	11/3/12, identified a ADL				
	(activities of daily livin					
	l `	nd locomotion (non-weight				
	bearing) and total dep	, ,				
		erventions directed staff to				
	· ·	ft for all transfers to/from				
	bed to wheelchair and					
	wheelchair to/from roo					
	transportation vehicle					
		ional problem related to				
		Il hygiene related to total				
		for performance. The care				
	plan interventions und					
	_	d 11/1/13, directed staff to				
	•	neals and staff to feed				
	resident and provide	•				
	swallowing /choking.					
		n in range of motion and				
	· ·	event further decline in				
	range of motion.					
		- DON 5/44/45 -+ 0:00				
		e DON on 5/14/15, at 3:28				
	•	vas currently being provided				
	· ·	an did not include R4's				
		lan to maintain or prevent				
	further decline in rang	ge of motion.				
	Dalo coro rier de - d'	d not address incomes and				
	·	d not address insomnia and				
		interventions to promote				
		ication to prevention urinary				
		current physician orders				
		d an order for Trazodone				
	(antidepressant comn					
		edtime. The medication was				
		iia, and was initiated prior to				
		revised 11/1/13, identified				
	psychotropic drug how	wever did not address				

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insomnia, use of medication and

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
		00234	B. WING		0	5/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
LAKE MIN	INETONKA CARE CENT	ER	UMMERVILLE ROA	VD.		
		DEEPHA	AVEN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 560	Continued From pag	e 8	2 560			
	non-pharmacological sleep.	I interventions to promote				
	acknowledged the ca	OON on 5/14/15, at 3:04 p.m. are plan did not include the e, nor non-pharmacological note sleep.				
	included an order for 250 mg take one fou three days of the mo (UTI) prevention which R4's care plan revise (activities of daily living related to toileting/rise total dependence on care plan did not direct	in orders dated 4/6/15, cephalexin (antibiotic) cap r times a day for the 1st inths for urinary tract infection ch was started on 9/17/14. Ed 11/3/13, identified a ADL ing) functional problem k of urinary incontinence to staff for performance. The ect staff to monitor for UTIs, rophylactic antibiotic included plan.				
	4:58 p.m. she indicat urinary tract infection 5/14, and prior to tha indicated the medica administered for the the first three days of	tion was reduced from being first 10 days of the month to f the month on 6/13. The the care plan did not include				
	R1's care plan did no preferences related t	ot address resident's o medication delivery.				
	R1, resident stated the practical nurse or LP medication to him that R1 further indicated to	.m. during an interview with nat a staff person (licensed N-A) administered at "messes up" his stomach. the nurse that the that ay "does not give medication				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING: _		COMPLETED		
		00234	B. WING		05/14/201	5
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
	INCTONIA OARE OENT		MERVILLE RO	DAD		
LAKE MIN	INETONKA CARE CENTI	ER DEEPHAV	EN, MN 55331			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)		IPLETE ATE
2 560	Continued From page	9	2 560			
	that messes up" his s	tomach.				
	R1's quarterly MDS dated 3/16/15, indicated R1 was cognitively impaired and identified a diagnosis of schizophrenia.					
	following: 1) On 10/9/ that NA had found res garbage in the day ro	ess notes revealed the '14 Informed by night nurse sident's medication in the omInformed 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 sto	omach." 2) On 10/22/14 the				
	several calls from the	porting he had received resident regarding stomach				
	problems that were not ombudsman was info	ot new to him. The rmed the resident had been				
	· · · · · · · · · · · · · · · · · · ·	king his medications, and an twice that month. 3) On				
	10/28/14 "Ombudsma	an heretold him would not ing/noc [night] nurses, he				
	feels that they are pu	tting poison on his meds and				
		ingested ben gay [topical er this year. Resident again				
		not accept meds from ing, noc shift but would				
	accept from nurses th	nat work during day. Call 5) On 10/30/14 Call to				
	psychologist to inform pm/eve [evening] nur	n of not taking meds from se."				
	R1's care plan revise	d 12/28/13, identified				
	resident as having im					
		impaired thought process				
		ecision making secondary to				
	long standing mental	**				
		ventions directed staff to n as ordered. The plan,				
		ide the need to schedule				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		00234	B. WING		05/14/2015
	ROVIDER OR SUPPLIER	20395 S ER	DDRESS, CITY, STATE UMMERVILLE ROA VEN, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
2 560	promote R1's compliand medications. In an interview with the p.m. she explained slifewer than six months care plans "are a profishe was prioritizing with planned to review all not found the time to SUGGESTED METH. The director of nursing develop, review, and/procedures to ensure ensure appropriate catesignee could educate the policies and proceduring systems to compliance.	ble during the day shift to ance with taking ne DON, on 5/14/15, at 4:53 ne had been at the facility s, but was aware resident blem." The DON explained rork and although she had the resident care plans, had do so. OD FOR CORRECTION: g (DON) or designee could for revise policies and care plans are developed to are of residents. The DON or ate all appropriate staff on edures, and could develop	2 560		
2 565	Plan of Care; Use Subp. 3. Use. A con	Subp. 3 Comprehensive nprehensive plan of care ersonnel involved in the	2 565		
	by: Based on observation	n, interview and document led to follow the care plan for al side effect of			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED	
		00234	B. WING		0	5/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
I AKE MIN	INETONKA CARE CENT	20395 SI	JMMERVILLE ROA	D		
LAKE WIII	INETONKA CARE CENTI	DEEPHA	VEN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From page	======================================	2 565			
		tion for 2 of 5 (R4, R10) or unnecessary medications.				
	Findings include:					
	dated 3/17/15, for har for paranoid psychos mg twice daily on 4/7 11/3/12, identified R4 psychotropic medical directed staff to obse side effects and reporeview every 30 days and primary medical phys (as needed) for effical pharmacist review of every month.	n orders revealed an order loperidol 0.5 mg twice daily is, which was increased to 1 /15. The care plan dated 4 as fall risk related to tions. The interventions rve for psychotropic drug rt to physician, psychiatrist is for efficacy and side effects sician every 60 days or PRN acy and side effects and psychotropic medications				
	being completed on 1 assessments were fo interview with the DO	12/29/07. No further TD bund in the record. In an bN on 5/14/15, at 3:04 p.m. able to find any DISCUS				
	revealed an order for medication) 9 mg dai disorder and bipolar of the care plan identification psychotropic medications are lated to bipolar disordirected staff to admit medications as order side effects and effect monitor/document/repreactions of psychotropic medications of psych	tions (Invega, divalproex) order. The interventions nister psychotropic ed by physician, monitor for				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00224	B. WING		05/4	4/2045
		00234			05/1	4/2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	•		
LAKE MIN	INETONKA CARE CENTI	ER	IMERVILLE RO EN, MN 55331	JAD		
(VA) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLETE DATE
2 565	Continued From page	e 12	2 565			
	effects (shuffling gait, frequent falls, refusal dry mouth, depressio isolation, blurred visic insomnia, loss of app cramps, nausea, vom not usual to the persopsychotropic medicat dosage and side effect evaluate all medication meds [medications] efficacy, dosage, and evaluate psychotropic or PRN for efficacy, dosage and side efficacy, dosage, and evaluate psychotropic or PRN for efficacy, dosage, and evaluate monitoring ressure monitoring references.	rigid muscles, shaking), to eat, difficulty swallowing, n, suicidal ideation, social on, diarrhea, fatigue, etite, weight loss, muscle iiting, behavior symptoms on, pharmacist to review ions monthly for efficacy, cts, primary physician to on, including psychotropics very 60 days or PRN for side effects, psychiatrist to or drug medications monthly losage and side effects. evidence of orthostatic blood elated to antipsychotic few of the record revealed oressure monitoring months. R10's record				
	p.m. stated she was a documentation in the orthostatic blood presside effects was done she would call the attan assessment was a When questioned regis assessed for TD, the ocheck our policy, by year." No further infoincluding a related possible SUGGESTED METH. The director of nursin review and revise polito ensuring the care possible side of the state of	record to indicate sures or assessment for TD e. The DON further stated ending psychiatrist to see if lone recently by psychiatrist. arding how often a resident ne DON stated "I would have ut would guess once a rmation was provided,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00234	B. WING		05	5/14/2015
	ROVIDER OR SUPPLIER	20395 SI	DDRESS, CITY, STATE JMMERVILLE ROA VEN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	and develop a monitor are providing care as of care.	op a system to educate staff oring system to ensure staff directed by the written plan	2 565			
2 895	Motion Subp. 2. Range of m that is directed toward through positioning a implemented and ma comprehensive reside of nursing services m development of a nur provides that: B. a resident with receives appropriate	sing care plan which a limited range of motion treatment and services to tion and to prevent further	2 895			
	by: Based on observation review, the facility fail rehabilitative services range of motion (ROI reviewed for ROM. Findings include: R4 was observed on	t is not met as evidenced n, interview and document led to provide nursing to maintain or improve M) for 1 of 1 resident (R4) 5/12/15, at 3:14 p.m. to both hands and knees and/or braces. The				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE COMP	
			A. BOILDING.			
		00234	B. WING		05/	14/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
I AKE MIN	INETONKA CARE CENTI	20395 SU	MMERVILLE RO	DAD		
LAKE WIII	INCTONNA CARE CENTI	DEEPHA	/EN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
2 895	Continued From page	e 14	2 895			
2 895	following day R4 was 7:45 a.m. while totally a nursing assistant (N of 5/13/15, at 1:12 p.r from her wheelchair tift. NA-A then assiste side to remove the month of the total side to remove the total side to t	observed at breakfast at a assisted with breakfast by IA)-A. During the afternoon m. NA-A transferred R4 obed using a mechanical at R4 in turning from side echanical lift transfer sheet. If on 5/13/15, at 1:14 p.m. brovide any range of motion A further explained she had be complete ROM exercises ted R4 did not utilize any and the stated R4 had knees, hands and hips. The A had "refused" ROM Im Data Set (MDS) dated ignoses of dementia and of one side of the body). A had cognitive impairment, required extensive ties of daily living (ADLs), imment on both sides of emities. The MDS also to receiving restorative occupational therapy. The at (CAA) dated 10/26/14, as contracture's of her	2 895			
	unit, dressing, eating, bathing."					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00234	B. WING		05/14	1/2015
	ROVIDER OR SUPPLIER	20395 SUM	DRESS, CITY, STA MMERVILLE RO EN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
2 895	intervention directed of all transfers and to from destinations. In a follow up intervier at 3:28 p.m. stated of conversation with R4's they indicated if the District they would pay for octoberapy evaluation. An attempted to approach had refused, but state again." DON reviewed unable to find any dowith R4 or her family. The director of nursing develop, review, and/procedures to ensure approvided to ensure approach and procedures, and systems to ensure on the formal transfer and transfer and procedures, and systems to ensure on the formal transfer and transf	t on staff in ADLs. The staff to use mechanical lift o propel wheelchair to and w with the DON on 5/14/15, we had a previous s family in 3/15 or 4/15, and a provided on the polysical strong the poly	2 895			
21220	Designation	Subp. 1 Medical Director; on. A nursing home must to serve as medical	21220			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		00234	B. WING		0:	5/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
I AKE MIN	INETONKA CARE CENT	ER 20395 S	UMMERVILLE ROA	D		
	INC FORMA GARLE GENT	DEEPHA	VEN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21220	Continued From pag	e 16	21220			
	by: Based on interview a facility failed to ensurand assurance (QAA required and maintai had the potential to a in the facility. Findings include: Review of the quality attendance logs from the facility QAA command 10/22/14, and he The medical director meeting, but not the a period of greater th meetings and attendant	a 5/1/14 to 5/14/15, identified mittee met twice on 5/25/14 eld no meetings in 2015. attended the 5/28/14 10/22/14 meeting. This was an 11 months between QAA ance by the medical director quarterly requirement and				
	administrator explain six months, but ackn held every six month administrator stated left the facility on 11/	5/15/15, at 1:20 p.m. the ed that the QAA met every owledged a meeting was not s over the past year. The the previous medical director 1/14, and the facility had cal director since that time.				
	A policy was request	ed but not provided.				
	The administrator or designate a physicial director of facility. The	dOD OF CORRECTION: designee could employ and n to serve as medical e administrator or designee w, and/or revise policies and				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	IED
		00234	B. WING		05/14	1/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
I AVE MIN	INETONKA CARE CENTI	20395 SU	MMERVILLE RO	DAD		
LAKE WIIN	INETONKA CARE CENTI	DEEPHAN	'EN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21220	Continued From page	e 17	21220			
	a medical director to a The administrator or a appropriate staff on the procedures. The admidevelop monitoring sycompliance	the facility consistently has ensure ongoing compliance. designee could educate all nese policies and hinistrator or designee could systems to ensure ongoing				
21426	21426 MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control		21426			
	 (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 Requiremen	t is not met as evidenced				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED
		00234	B. WING		05	5/14/2015
	ROVIDER OR SUPPLIER	20395 S	NDDRESS, CITY, STATE			
LAKE WIII	INCTONNA CANE CENT	DEEPHA	AVEN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21426	Continued From pag	e 18	21426			
	facility failed to ensur	and document review, the re 1 of 2 newly hired staff as screened for tuberculosis				
	Two employees had the past four months practical nurse (LPN) 4/22/15. E-1's persor), and had been hired on nnel file lacked evidence the screened for TB symptoms,				
	Mantoux testing had although E-1 had bee care since 4/24/15. T was utilizing the Minr Health's (MDH) Rule	en providing direct resident The DON reported the facility nesota Department of s and Recommendations for ing, Prevention, and Control				
	nursing home must e prior to employment. tuberculosisAll emp intradermal tuberculii	nts for employees read, "A ensure that all employees, show freedom from active bloyeesmust have an in test with purified protein within three months prior to				
	director of nursing or staff have had sympt to ensure no active d residents. An auditin ensure all staff have	dod of correction: The designee, could ensure all om screening and TB testing disease prior to working with a tool could be developed to been screened as required.				
	(21) days.	CORRECTION: Twenty-one				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
7.11.2.1.2.11.1		.52	A. BUILDING: _		00 22.25
		00234	B. WING		05/14/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		20395 SUI	MMERVILLE RO	DAD	
LAKE MIN	INETONKA CARE CENTI	ER	EN, MN 55331		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
21530	A. The drug regimer reviewed at least mor currently licensed by This review must be a Appendix N of the Sta	the Board of Pharmacy. done in accordance with ate Operations Manual,	21530		
	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				
	B. The pharmacis irregularities to the did and the attending phy must be acted upon by	ect to frequent change. st must report any rector of nursing services vsician, and these reports by the time of the next ner, if indicated by the			
	pharmacist. For purp upon" means the acc report and the signing of nursing services ar	oses of this part, "acted eptance or rejection of the gor initialing by the director 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				
	refer the matter to the if the medical director	ted, the pharmacist must e medical director for review is not the attending ical director determines that			
	the attending physicial justification for the ord physician does not characteristics.	an does not have adequate der and if the attending nange the order, the matter			
	by part 4658.0070. If	trance committee required the attending physician is the consulting pharmacist directly to the quality			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		00234	B. WING		05/	14/2015
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LAKE MIN	NETONKA CARE CENTE	R	MMERVILLE RO /EN, MN 55331	DAD		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)		COMPLETE DATE
21530	Continued From page	20	21530			
	by: Based on interview ar consultant pharmacis regimens were free from medications for 4 of 5 R10) reviewed for unreside include: R9 was prescribed the 50 mg daily since 8/4/lacked evidence of monine months for the progressure monitoring (pressure with position or sitting up from a lyi antipsychotic use. The (MDS) dated 3/15/15, ambulated independent two falls since the president months for RS R7 was prescribed the needed (PRN), however not identified an including orthostatic hyskinesia (or TDne characterized by repellong-term use of certain antipsychotics). R7's current physician revealed an order for	residents (R9, R7, R4, necessary mediation use. e antipsychotic, clozapine (14. R9's record, however, onitoring in the previous otential for orthostatic blood a sudden drop in blood a change, such as standing ng position) related to e annual Minimum Data Set revealed the resident ently and had experienced evious assessment period. harmacist reviews revealed of drug irregularities over (2). e antipsychotic Seroquel as ver, specific target behaviors d potential side effects hypotension and tardive urological syndrome etitive, involuntary movement				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00234	B. WING		05/14/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
LAKE MIN	NETONKA CARE CENTI	ER .	MMERVILLE RO	DAD	
040.15	STIMMADA ST	ATEMENT OF DEFICIENCIES	/EN, MN 55331	PROVIDER'S PLAN OF CORRECT	ION (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETE
21530	Continued From page	e 21	21530		
	The medication was of attending psychiatrist	ordered on 12/12/14, by the			
	indicated R7 was adn follows during the pre 1) In 1/15 administe anxiety five times, cor and per resident requ 2) In 2/15 administe anxiety, restlessness. "outbursts/anxiety/cry 3) In 3/15administer screaming and swear 4) In 4/15administer as documented two of R7's record revealed blood pressure monit completed in the prev Tracking Forms (incid	red seven times for c/o implaints of aviation one time rest one time red three times "res c/o , sadness" and ring." red one times for "yelling, ring." red three times for "anxiety" if three times administered. no evidence of orthostatic oring having been			
	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."				
	System Condensed Uto diagnose potential	a Dyskinesia Identification Jser Scale (DISCUS), used TD, was dated as last ed in 6/12. No further TD			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SLIBVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,			LETED
			A. BOILDING.			
		00004	B. WING			44/004#
		00234	5		05/	14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
I AKE MIN	INETONKA CARE CENTE	20395 SU	MMERVILLE RO	DAD		
LAKE WIII	INCTONNA CANE CENTE	DEEPHA	/EN, MN 55331			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO		COMPLETE DATE
		,		DEFICIENC	CY)	
21530	Continued From page	. 22	21530			
21000	. •		21000			
	assessments were for	und in the record.				
	In addition D7 was al	so prescribed oxybutynin				
	(Ditropan) 5 mg twice					
		/14. Physician progress				
		3/26/15, lacked justification				
	for the continued need	d of oxybutynin and whether				
	the benefits outweigh	ed potential anticholenergic				
	side effects. R7's quarterly MDS dated 2/11/15, identified R7					
	,	incontinent of urine (fewer				
	-	a week) with no toileting				
	program.					
		narmacist reviews from				
		vealed no recommendations				
	of drug irregularities of	over past 10 months for R7.				
	In an interview with th	e director of nursing (DON)				
		m. she reported she was				
	unable to find any doo	cumentation in R7's record				
		blood pressures or TD				
		en completed. The DON				
	further stated she wor					
		in assessment had recently				
	=	eir office. When questioned sting for TD for a resident on				
		ion the DON stated, "I				
		our policy, but would guess				
		49 p.m. the DON stated that				
	R7 was previously prescribed Haldol					
	(antipsychotic) PRN, I	but was since it interfered				
		on, it was discontinued and				
		The DON indicated she				
		a related policy, and no				
		as provided related to TD				
	assessment.					
	R4's was current phys	sician orders dated 4/6/15,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00234	B. WING		05/14	l/2015
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 00.1	
LAKE MIN	INETONKA CARE CENTE	ER	IMERVILLE RO EN, MN 55331	DAD		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
21530	commonly prescribed bedtime. The medical insomnia, and was in medical record lacked assessment of sleep potential causal facto documentation of nor interventions and the interventions tried prices sleep aid and monitor determine the effective medication. In addition reduction for greater that attempted. R4's physician progres on 4/6/15, 2/215, 12/12/1/14, progress not generally a little more. Review of the psychian notes revealed no documentation. R4's Night Shift Montunder the category of mark on "sleeps through the category of mark on sleeps through the category of the categ	Trazodone (antidepressant for insomnia) 50 mg at tion was prescribed for itiated prior to 6/4/14. R4's devidence of an patterns, identification of rs for sleep disturbance, a-pharmacological effectiveness of or to the initiation of the ring of hours of sleep to reness of the the sleep aid in, no attempt at a dose than 11 months was ress notes, revealed a note 1/14 "Sleeping well." Also on the indicated "Overall feels of atigued than in the past." Attrist/physician progress cumentation to justify the on and continued need of the continued need of the continued than the past. The continued has a check than 1 months with a check than 1	21530			

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00234	B. WING		05/1	4/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
LAKE MIN	INETONKA CARE CENTE	ER .	MMERVILLE RO 'EN, MN 55331	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21530	sleep hours to determ was found. The monthly consultate 6/30/14 to 4/12/15, reformed of drug irregularities of the following order dated 3/17/15, and the following to 1 mg twice daily or revealed a DISCUS of further TD assessment. In an interview with the p.m. she verified the following system for monitoring hygiene assessment medication to promote nursing staff had been sheet that contained of patterns. The flow sheet that contained of patterns. The flow sheet that contained in was unable to find an since 12/29/07 for R4. R10's current physicial revealed an order for medication) 9 mg dail disorder and bipolar of the record for R10 la	ote sleep and monitoring of nine efficacy of medication Int pharmacist reviews from vealed no recommendations over past 10 months for R4. In orders also revealed an for haloperidol 0.5 mg twice chosis, which was increased a 4/7/15. Further review ompleted 12/29/07. No into the month of hours of sleep or a sleep for residents who utilized the sleep. The DON explained in completing a monthly flow check boxes related to sleep thad noted 1) sleeps and off; and 3) sleep less use of the flow sheet had 1/15. The DON reported she by DISCUS assessment.	21530	DEFICIENCY)		
	medication use, and r					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			D WING			
		00234	B. WING		05/1	4/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LAKE MIN	INETONKA CARE CENTI	ER .	MMERVILLE RO	DAD		
			'EN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21530	O 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.		21530			
	p.m. stated she was u documentation in the orthostatic blood pres The DON further state attending psychiatrist was completed recen questioned regarding assessed for TD, the to check our policy. It provided. Policies we provided.	record to indicate ssures or a TD assessment. ed she would call the to see if an assessment tly by psychiatrist. When how often a resident was DON stated "I would have No further information was re requested but not				
	5/18/15. LPN-A furth surveyor contact information	be available until Monday, er stated she had the				
	On 5/22/15, at 1:45 p was called but was u	.m. consulted pharmacist nable to be reached.				
	The director of nursin consulting pharmacis policies and procedur medication usage and necessary. The DON	OD OF CORRECTION: g (DON) or designee and t could review and revise res for proper monitoring of d educate nursing staff as or designee, along with the dit medication reviews on a re compliance.				
	TIME PERIOD FOR (21) days.	CORRECTION: Twenty-one				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
			7 BOILDING.		
		00234	B. WING		05/14/2015
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
LAKE MIN	INETONKA CARE CENTE	ER	IMERVILLE RO	DAD	
			EN, MN 55331		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
21535	Subpart 1. General. must be free from unrunnecessary drug is a A. in excessive detherapy; B. for excessive detherapy; C. without adequed D. in the presence which indicate the doctor discontinued. In addition to the drug part 4658.1310, the rewith provisions in the Code of Federal Regulations Manual, Coperations Manual, Communications of the design of the code of Federal Regulations Manual, Coperations Manual, Communications of the code of Federal Regulations of the code of the code of Federal Regulations of the code of Federal Regulatio	A resident's drug regimen necessary drugs. An any drug when used: ose, including duplicate drug	21535		
	Health Care Financing This standard is incorravailable through the system and the State subject to frequent ch	and Human Services, g Administration, April 1992. porated by reference. It is Minitex interlibrary loan Law Library. It is not lange. t is not met as evidenced			
	by: Based on observation review, the facility fail side effect of antipsycensure efficacy of sleedocumented for 4 of 8 residents reviewed for	n, interview and document ed to monitor for potential chotic medication and/or to ep medication was			
	Findings include:				
	R9 was prescribed the	e antipsychotic, clozapine			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00234	B. WING	B. WING		4/2015
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	•	
	20395 SUI	MMERVILLE RO			
LAKE MINNETONKA CARE CENTE	ER DEEPHAV	EN, MN 55331			
PREFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
21535 Continued From page	e 27	21535			
50 mg daily since 8/4. lacked evidence of m nine months for the p pressure monitoring (pressure with position or sitting up from a lyi antipsychotic use. Th (MDS) dated 3/15/15, ambulated independent two falls since the present work of the presen	onitoring in the previous otential for orthostatic blood a sudden drop in blood a change, such as standing ing position) related to e annual Minimum Data Set revealed the resident antly and had experienced evious assessment period. The antipsychotic Seroquel as ver, specific target behaviors in dipotential side effects in the properties of potential side effects in divide eviological syndrome estitive, involuntary movement ain drugs, including in mistering her insulin with the afternoon, at 2:25 p.m. in ursing assistant (NA)-B liker in the hallway. The orders dated 4/10/15, Seroquel 50 milligrams of four hours for agitation. Ordered on 12/12/14, by the instration Record (MAR) in inistered Seroquel as vious four months: red seven times for c/o implaints of aviation one time est one time red three times "res c/o"	21535			

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	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		00234	B. WING		0.5	44/2045
		00234			05/	14/2015
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
LAKE MIN	INETONKA CARE CENTI	ER .	MMERVILLE RO	DAD		
	T		/EN, 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 OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21535	Continued From page 28		21535			
2.000	3) In 3/15administer screaming and swear 4) In 4/15administer as documented two control of the strength of the strength of the strength of the scream of the room. Diagnoses hypertension, diabeted depression and Parking indicated R7 showed and exhibited no behataken antidepressant.	red one times for "yelling, ring." red three times for "anxiety" of three times administered. rated 2/11/15, indicated the rely intact, and was robility, transferring and with supervision outside of a on the MDS included res, schizophrenia, anxiety, rison's disease. The MDS minimal signs of depression revioral problems. R7 had				
	having potential the paggressive (yelling, eslamming doors) relaillness, ineffective copimpulse control most redirections/corr	ted to mental, emotional bing skills, having poor commonly in response to n or if she felt she was not ion from others. The goal lent will have no more than 1 eek." Interventions directed edications as ordered, a side effects and re plan also identified R7 as medications (clozapine, ER, and Seroquel as hizoaffective disorder, ety. The interventions				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00234	B. WING		05/1	14/2015
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, STA	•		
LAKE MI	NNETONKA CARE CENTI	ER .	MMERVILLE RO EN, MN 55331	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21535	efficacy, side effects, applicable, educate the risks, benefits and the symptoms of psychotromonitor/document/repreactions of psychotrogait, tardive dyskines effects (shuffling gait, R7's record revealed blood pressure monitocompleted in the prevention of the prev	and dosage reduction if the resident/caregivers about the side effects and/or toxic ropic medication, bort PRN any adverse opic medications: unsteady ia, extrapyramidyl side rigid muscles, shaking). The residence of orthostatic oring having been rious 11 months. Fall dent reports) revealed R7 wing falls in the last five The ambulating witnessed; The ambulating th	21535			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00234	B. WING		05/14	4/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STAT	TE, ZIP CODE		
LAKE MIN	INETONKA CARE CENT	ER	MMERVILLE RO /EN, MN 55331	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
21535	page 55		21535			
	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.					
	resident had bladder improper toileting had resident will be contined the interventions directly two hours during the incontinence, wake events and bladder incontinence.	I on 11/29/13, indicated the incontinence related to bits. The goal stated "The ment during waking hours. Exceed staff to check every night and as required for every two hours at night to signs and symptoms of				
	on 5/14/15, at 4:46 p. unable to find any dod to indicate orthostatic assessments had bee further stated she worpsychiatrist to see if a been completed in the about frequency of te antipsychotic medical would have to check once per year." At 4: R7 was previously pre (antipsychotic) PRN, with another medicati Seroquel was added. was unable to locate	an assessment had recently eir office. When questioned sting for TD for a resident on tion the DON stated, "I our policy, but would guess 49 p.m. the DON stated that				
	included an order for	sician orders dated 4/6/15, Trazodone (antidepressant for insomnia) 50 mg at				

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WIIIIIICSOL	a Department of Fleatt	 				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	= I ED
		00234	B. WING		05/4	4/2015
		00234			03/1	4/2015
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		20395 SUN	IMERVILLE RO	DAD		
LAKE MIN	NETONKA CARE CENTE	ER DEEPHAVI	EN, MN 55331			
	OLIMANA DV OT		1	DDOLUBERIO DI ANI OE CORRECTIO		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG	•	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE		DATE
				DEFICIENCY)		
21535	Continued From none	- 24	21535			
21000	Continued From page	31	21555			
	bedtime. The medicat	tion was prescribed for				
	insomnia, and was ini	itiated prior to 6/4/14. R4's				
	medical record lacked					
	assessment of sleep	patterns, identification of				
		rs for sleep disturbance,				
	documentation of non	•				
	interventions and the	· ·				
		or to the initiation of the				
	sleep aid and monitoring of hours of sleep to					
	determine the effectiveness of the the sleep aid					
		n, no attempt at a dose				
	reduction for greater t	•				
	attempted.					
	During the morning of	f 5/13/15, at 7:45 a.m. NA-A				
		ng total assistance to R4				
		the afternoon at 1:12 p.m.				
		from her wheelchair to bed				
		ft. NA-A then assisted R4 in				
	_	to remove the mechanical				
	lift transfer sheet.					
	R4's physician progre	ess notes, revealed a note				
		1/14 "Sleeping well." Also on				
		e indicated "Overall feels				
		fatigued than in the past."				
	,	<u> </u>				
	Review of the psychia	atrist/physician progress				
		cumentation to justify the				
		on and continued need of				
	the Trazodone.					
	R4's quarterly MDS d	ated 1/26/15, identified				
	cognitive impairment					
	dementia. The MDS	•				
		ired or having little energy,				
		pressant medication daily				
		ays of the assessment				
	period.	2,0 0. 110 000001110111				
	poriou.		1	I .		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY PLETED	
		00234	B. WING		05	5/14/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
LAKEMIN	INICTONICA CADE CENT	20395 SL	JMMERVILLE ROA	D		
LAKE WIII	NNETONKA CARE CENT	DEEPHA	VEN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21535	R4's Night Shift Monunder the category of mark on "sleeps thro" "Trazodone at HS [hu In addition, on 12/8/1 resident "sleeps thro" R4's care plan dated mood/behavior probled lusions and being identification of problem R4's integrated programmentation related sleep or non-pharmal utilized to promote slate record, no documentation to identificators and potential interventions to promosleep hours to determ was found. R4's current physicial order dated 3/17/15, daily for paranoid position 1 mg twice daily or revealed a DISCUS further TD assessment in an interview with the p.m. she verified the system for monitoring hygiene assessment medication to promonursing staff had been sheet that contained patterns. The flow she through; 2) awake or	thly Charting dated 1/1/15, f Sleep Pattern, had a check ugh" and hand written note ours of sleep] for insomnia." 4, it was also noted the ugh." 11/3/12, identified a em related to dementia, critical of others, but lacked ems with insomnia. ress notes contained no ed to monitoring of hours of cological interventions eep. Upon further review of	21535			

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STATEMENT	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURV	
		00234	B. WING		05/14/2	2015
NAME OF D					05/14/2	.015
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA MMERVILLE RO			
LAKE MIN	INETONKA CARE CENTE	ER .	'EN, MN 55331			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
21535	5 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.		21535			
	ambulating independer residents sitting in data current physician order an order for Invega (a	n 5/13/15, at 8:15 a.m. ently and visiting with other yroom area. The resident's ers signed 4/2/15, revealed entipsychotic medication) 9 er compulsive disorder and ed on 1/8/14.				
	resident had no cogni diagnoses of hyperter schizophrenia. The re antipsychotic medicat seven days during the	ion daily over the previous e assessment period. The 10 as being independent in				
	blood pressure monitor medication use, and r pressure monitoring h	cked evidence of orthostatic oring related to antipsychotic no orthostatic blood nad been recorded in the n addition, a DISCUS had				
	p.m. stated she was u documentation in the orthostatic blood press The DON further state attending psychiatrist was completed recen questioned regarding assessed for TD, the	record to indicate sures or a TD assessment.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			B. WING				
		00234	B. WING		0	5/14/2015	
NAME OF PR	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
LAKE MIN	NETONKA CARE CENTI	ER	UMMERVILLE ROA	ND .			
		DEEPHA	VEN, MN 55331				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION	ROVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE -REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETE DATE		
21535	Continued From page 34 Policies were requested but not provided.		21535				
21610	director of nursing (Edevelop, review, and/procedures to ensure regimes are free from The DON or designed appropriate staff on the and could develop a congoing compliance. TIME PERIOD FOR (21) days. MN Rule 4658.1340 Sand Preparation Area Subpart 1. Storage of must store all drugs in under proper temperation.	resident's medications a unnecessary medications. e could educate all ne policies and procedures monitoring system to ensure CORRECTION: Twenty-one Subp. 1 Medicine Cabinet ;Storage of drugs. A nursing home in locked compartments ature controls, and permit	21610				
	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:						
	5/14/15, at 6:58 p.m. (LPN)-A informed sur emergency kit was st	f medication storage, on licensed practical nurse veyor the facility's ored in the refrigerator in the PN-A and the surveyor					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00234	B. WING		0:	5/14/2015	
	ROVIDER OR SUPPLIER	20395 S	ADDRESS, CITY, STATE UMMERVILLE ROA AVEN, MN 55331				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLE* DATE			
21610	removed the emerge padlock on the outsic removed the padlock emergency kit include medication including and Risperdal Constant During an interview of director of nursing and that the staff generall shut and sometimes stated the emergency been locked with the the only staff who had A policy was requested SUGGESTED METH director of nursing (Indevelop policies and medications are store accessible to authorize designee could educations and prodesignee could develop solicies and prodesignee could develop solicies and prodesignee could develop solicies and prodesignee could develop congruence ongoing compare the staff of the surrection of t	the door was found and the refrigerator and not kit, which had an open are of the container. LPN-A, and the contents of the ed unopened injectable insulin, Ativan (antianxiety) a (antipsychotic). In 5/15/15, at 2:45 p.m. the adadministrator explained by pulled the kitchen door locked the door. The staff by kit should have always padlock and the nurse was ad the key. In 5/15/15, at 2:45 p.m. the adadministrator explained by pulled the kitchen door locked the door. The staff by kit should have always padlock and the nurse was ad the key. In 5/15/15, at 2:45 p.m. the adaministrator explained by pulled the kitchen door locked the door. The staff by kit should have always padlock and the nurse was ad the key. In 5/15/15, at 2:45 p.m. the door locked the door. The staff by kit should have always padlock and the nurse was ad the key. In 5/15/15, at 2:45 p.m. the door locked the door locked the door. The staff by kit should have always padlock and the nurse was at the key.	21610				
21942	Resident and Family Resident advisory co boarding care home advisory council and	10 Subd. 8b Establish Councils uncil. Each nursing home or shall establish a resident a family council, unless cons express an interest in	21942				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00234	B. WING		05/1	4/2015
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
LAKE MIN	INETONKA CARE CENTI	ER	MMERVILLE RO	DAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM			(X5) COMPLETE DATE
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:		21942	DEFICIENCY)		
	A letter dated 1/31/14 attempts at forming a by the administrator interviewed on 5/15/1 thought the last attem had been made in the acknowledged the last than a year prior (15 SUGGESTED METH The administrator or cindividual to be response to establish a family of would need to docum council, and identify with the calendar year.	st attempt had been greater				

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