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: HNJ1

Facility ID: 00271

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

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

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

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

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

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

6. DATE OF SURVEY **09/11/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **131** (L18)

13. Total Certified Beds **131** (L17)

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:

____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	131			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathleen Lucus, Unit Supervisor 09/15/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Certification Specialist 09/15/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY

_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00320** (L31)

30. REMARKS

Posted 09/27/2017 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **08/30/2017** (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245210 September 14, 2017

Ms. Lydia Buetow, Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, MN 55384

Dear Ms. Buetow:

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 29, 2017 the above facility is recommended for:

131 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 131 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 14, 2017

Ms. Lydia Buetow, Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, MN 55384

RE: Project Number S5210026

Dear Ms. Buetow:

On August 8, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 20, 2017. 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 September 11, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 8, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 20, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 29, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 20, 2017, effective August 29, 2017 and therefore remedies outlined in our letter to you dated August 8, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

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PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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(L4) **4527 SHORELINE DRIVE**
(L5) **SPRING PARK, MN** (L6) **55384**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **06/03/2010**
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FISCAL YEAR ENDING DATE: (L35) **09/30**

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To (b) :

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13.Total Certified Beds **131** (L17)

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

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	131			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Andrea Schmitz, HFE NE II 08/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/30/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
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03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
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OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00320** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **08/30/2017** (L33)

DETERMINATION APPROVAL

Electronically delivered
August 8, 2017

Ms. Lydia Buetow, Administrator
Lake Minnetonka Shores
4527 Shoreline Drive
Spring Park, MN 55384

RE: Project Number S5210026

Dear Ms. Buetow:

On July 20, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be 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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 29, 2017, 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 August 29, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 20, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 20, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic 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.

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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245210	A. BUILDING ______ B. WING ______	07/20/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 7/17-7/20/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 157		8/29/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 08/18/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245210	A. BUILDING ______ B. WING ______	07/20/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident or designee was notified of a change in treatment related to starting a new medication for 1 of 1 resident (R258) reviewed for notification of change. Findings include: R258's Admission Record, dated 7/13/17,	F 157	Corrective Action: Resident family was notified of the change in medication. Corrective Action as it Applies to others: Residents were reviewed for change in medication on 7/17/17. Policy and procedure reviewed and current. All residents who are identified as unable to make own decisions will have their	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245210	A. BUILDING ______ B. WING ______	07/20/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 included diagnoses of compression fracture of lumbar vertebra, hypertension, and dementia, and listed family member (F)-B as the power of attorney and emergency contact #1. R258's BIMS (Brief Interview for Mental Status) and Delirium assessment, dated 7/19/17, indicated R258 was unable to complete the assessment. R258's Individual Resident Care Plan, initiated 7/13/17, indicated R258 required assistance with all activities of daily living. During interview on 7/20/17, at 12:47 p.m. F-B stated R258 was started on a new heart medication on 7/14/17, and neither F-B or R258's responsible party was notified. F-B stated she happened to be in R258's room when a male nurse brought in a medication to administer to R258. When F-B questioned the nurse about the medication, he stated it was her medication for her heart rate and blood pressure. F-B stated R258 had not been on a medication for her heart, so she was "caught off guard." F-B stated she wasn't notified until Monday, 7/17/17, because she had been asking questions about it. R258's current orders included an order on 7/14/17, written by nurse practitioner (NP)-A for "Metoprolol Tartrate [used to treat conditions affecting the heart] 12.5 mg [milligrams] (po) [by mouth] BID [twice daily]. Hold for HR [heart rate] < [less than] 70 or SBp [systolic blood pressure] < 110. Monitor Bp & HR TID [three times daily] x 48 hrs [hours]." Review of R258's progress notes from admission on 7/13/17 through 7/20/17 lacked documentation for starting the Metoprolol or that R258's F-B or responsible party was notified of the change in	F 157	legal representative notified of changes in medication. Staff educated at In Services during the week of 8/21/2017 and ongoing regarding policy for change of condition as it relates to medication changes and family notification. All residents are assessed upon admission quarterly and as needed for change in condition Corrective Action will be monitored by: Audits will be done weekly of 10 % of random selected residents on each Household to ensure changes in medication are reported to legal representative. Compliance: 1. The DON or designee will be responsible for completion of the audits. 2. The QA committee will be responsible for review and setting future audits. 3. DON will be responsible for compliance.	

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	245210	A. BUILDING ______ B. WING ______	07/20/2017

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F 157	Continued From page 3	F 157		

her treatment.

During interview on 7/20/17, at 1:07 p.m. registered nurse (RN)-A stated nursing staff would notify the first emergency contact person listed when there was a change in treatment or an accident involving the resident, unless the resident "was their own person."

During interview on 7/20/17, at 1:13 p.m. NP-A stated R258's new medication was added in the afternoon on Friday (7/14/17) due to her heart rate being elevated. NP-A stated F-B was not in the facility at that time. NP-A stated, "It is ideal to let them know, but it doesn't always happen. She wasn't here. I suppose I could have called her, but then you play phone tag."

During interview on 7/20/17, at 3:00 p.m. the director of nursing (DON) stated, "We notify family. We usually call family to let them know that there's been a medication change. Within the day, they should know about the change."

Facility policy, Change of Condition Family or Responsible Party Notification, dated 12/14, indicated the family and/or resident representative would be notified any time there was a change in condition, change in medication, change in mental, psychosocial or behavior management, or a significant change in the plan of care. The policy directed, from 8:00 am to 10:00 pm, notification was to occur within ½ to 1 hour of the incident or change. Also included, staff were to document in the resident's medical record, when the responsible party was notified or attempts made in two hour increments to notify them.

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F 241	Continued From page 4	F 241		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident’s individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a dignified experience by ensuring grooming services related to facial hair were provided for 2 of 3 residents (R20, R26) reviewed for activities of daily living (ADLs). Findings include: R20's annual Minimum Data Set (MDS), dated 5/19/17, indicated R20 was cognitively intact and required extensive assistance of one staff for personal hygiene cares. R20's ADLs Care Area Assessment (CAA), dated 5/24/17, identified a diagnoses of anxiety, depression, and "hypoparathyroidism Alzheimer's (sic)." R20 was alert and oriented with some confusion. R20 needed assistance with all activities of daily living (ADL). R20's current care plan, dated 5/24/17, indicated an activity of daily living self-care performance deficit. R20 required assistance of one staff for personal hygiene cares. The TASKS section in R20's electronic medical record (EMR) indicated R20 received a bath on	F 241	Corrective Action: Resident 20/26 was checked for grooming and both residents were shaved. Policy and procedure reviewed and current. Corrective Action as it applies to other residents: All residents were reviewed as to whom assistance with facial hair would need care. Staff was educated at an In Service during the week of 8/21/2017 regarding policy for shaving/grooming. Resident s preference for grooming will be honored as requested. Facility will make tools available to staff and residents. Corrective Action will be monitored by: Audits done weekly for 10% of randomly chosen residents who have had their bath. Shaving will be checked at this time. Shaving will be monitored as well on non bath days to ensure resident are shaved and nail care is done to preference. All residents are reviewed for their preferences and ADL choices on	8/29/17

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F 241	Continued From page 5 7/10/17, 7/13/17 and 7/17/17. R20 had no refusal of cares. During observation and interview with R20 on 7/18/17, at 9:34 a.m. R20 was observed to have several long, curled hairs on the chin and above the lip. R20 stated the facial hair "bothers me very much, embarrassing," R20 stated she would like the hairs removed, but staff do not allow her to have a tweezers. During observation and interview on 7/19/17, at 9:02 a.m. R20 continued to have several long, curled hairs on the chin and above the lip. R20 stated "I need that taken care of." R20 went on to say, "I'm so embarrassed. They are going to call me the bearded lady pretty soon." R20 stated she could not recall the last time someone helped her remove her facial hair. During observation on 7/20/17, at 8:20 a.m. nursing assistant (NA)-B was observed pushing R20 in a wheelchair out of the tub room and into the dining room. R20's continued to have several long, curled hairs on the chin and above the lip. During interview on 7/20/17, at 9:19 a.m. NA-B stated she assisted R20 with a tub bath prior to breakfast. NA-B stated R20 needed assistance with personal cares and did not refuse cares. NA-B stated during the bath, she asked R20 if she wanted the facial hairs shaved and the resident requested to wait until after breakfast. During an interview on 7/20/17, at 9:25 a.m. licensed practical nurse (LPN)-D stated due to a history of over plucking causing facial sores, R20 was not allowed to use a tweezers; R20 needed staff assistance to shave. LPN-D stated R20 was	F 241	admission, during quarterly care conferences, annual assessments and with a change in condition Compliance: 1. The DON or designee will be responsible for completion of the audits. 2. The QA committee will be responsible for review and setting future audits. 3. DON will be responsible for compliance.	

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F 241	Continued From page 6 able to ask for assistance and would usually tell staff when she wanted the facial hair removed. LPN-D observed R20's facial hair and stated the hair was long. R26's significant change ADL CAA, dated 11/1/16, identified a diagnosis of dementia and had been placed on hospice. The CAA noted R26 was able to be understood and was able to understand staff, had verbal behaviors related to yelling out, and needed extensive assistance with personal hygiene. The CAA did not indicate R26 rejected cares. R26's quarterly MDS, dated 4/28/17, indicated a severe cognitive impairment and needed extensive assistance of one staff to complete personal hygiene. The MDS further indicated R26 did not display rejection of cares behaviors during the assessment period. R26's care plan, revised on 11/7/16, identified a deficit in ADL self care related to advancing dementia, behaviors, pain, and depression. The care plan goal indicated R26 was to improve current level of participation in grooming, and specifically directed "I require 1 staff participation with personal hygiene and oral care." During observation on 7/18/17, at 8:57 a.m. R26 was observed sitting in her wheelchair; short white hairs were observed on R26's chin, with long white hairs observed in the corners of her upper mouth by her lip. At that same time, a white and pink electric razor was observed resting on the right side of R26's bathroom sink. During interview on 7/18/17, at 9:58 a.m. family member (FM)-A stated R26 would be bothered by	F 241		

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F 241	Continued From page 7	F 241		

the facial hair, stating there used to be a staff member who would shave them off. FM-A had noticed the facial hair the past couple of weeks.

During observation on 7/19/17, at 7:06 a.m. R26 was observed with the same short white chin hairs and the same longer white hairs curling around the sides of her mouth. The white and pink razor continued to sit on the right side of R26's bathroom sink.

During interview on 7/19/17, at 1:36 p.m. NA-C stated she had completed R26's cares that morning, and R26 needed assistance with her personal hygiene. NA-C stated if R26 wanted to shave, then they would shave her, but further stated she had not offered to shave R26 with morning cares. NA-C reported R26 "doesn't really refuse" shaving, "You have to let her know you are going to shave, then [R26] will say yes." NA-C verified the pink and white shaver was R26's personal shaver kept in her bathroom.

During interview on 7/20/17, at 2:20 p.m. the director of nursing (DON) stated shaving was always individualized to the resident, but should be done at a minimum for women once a week with their bath. The DON further stated residents were to be shaved when they visualized facial hair, and if a resident was not receptive, then there should be documentation of refusals. The DON stated facial hair was "a dignity issue for sure," not only for females but for males as well.

A facility policy entitled Dignity, reviewed 9/15, directed that "residents are cared for in a manner and in an environment that promotes maintenance and/or enhancement of each resident's quality of life." The policy further

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

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F 241	Continued From page 8 directed that assignment sheets were "completed on admission and will be updated as needed with noted preferences."	F 241		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with grooming related to facial shaving for 1 of 3 residents (R115), reviewed for activities of daily living (ADLs) and required limited staff assistance. Findings include: R115's admission record, dated 5/12/17, identified diagnoses which included multiple sclerosis and weakness. R115's admission Minimum Data Set (MDS), dated 5/24/17, identified R115 had moderate cognitive impairment, required limited assistance for personal hygiene, and did not reject cares. R115's ADLs care area assessment (CAA), dated 5/24/17, indicated R115 required assistance of staff with all aspects of ADLs due to physical limitations such as weakness and essential tremors. R115's care plan, last revised 5/31/17, indicated	F 311	Corrective Action: Resident 115 was shaved. Policy and procedure reviewed and current. Corrective Action as it applies to other residents: All residents were reviewed as to whom assistance with grooming and shaving needs would need care. Staff was educated at an In Service during the week of 8/21/2017 regarding policy for grooming and shaving. Resident s preference for grooming will be honored as requested. Facility has equipment available to staff and residents to use. Corrective Action will be monitored by: Audits done weekly for 10% of randomly chosen residents. Shaving will be monitored as well on non bath days to ensure residents are shaved and nail care is done to preference. All residents are reviewed for their	8/29/17

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F 311	Continued From page 9 R115 required staff assistance with personal hygiene care. The care plan further identified R115 desired to be clean and well dressed. R115's resident care sheet, undated, indicated R115 required assistance of one staff member to assist with grooming. During an initial observation on 7/17/17, at 5:32 p.m. R115 was seated in a motorized wheelchair in his room. Gray/white whiskers, approximately 1/4" long, were observed on R115's upper lip, chin, neck, and nostrils. The nostril hairs contained white debris. When asked about his facial hair, R115 stated he had not shaved for about a week. R115 stated he didn't have a razor here at the facility, but there was one available for him to use. R115 stated the staff don't always offer to bring him a razor or offer to help him and stated, "I need help to get all the hair." R115 stated he asked for a razor this morning, but they got busy. I didn't ask again." During a follow-up interview on 7/18/17, at 1:25 p.m. R115 was again in his room, sitting in the wheelchair. R115 stated he had shaved this morning with assistance, and added, "I can do it myself, but it's faster if they do it." R115 stated he shakes sometimes and it's difficult for him to shave, because he misses hair. R115 stated he liked being "clean shaven" and would prefer to shave every day, and would like the staff to offer him a razor every day. R115 stated he didn't have a razor here because his doesn't work well, but the one they use here at the facility works well, and added, "They just don't offer." During interview on 7/20/17, at 9:14 a.m. R115 had facial hair, approximately 1/8" long, on his	F 311	preferences and ADL choices on admission, during quarterly care conferences, annual assessments and with a change in condition Compliance: 4. The DON or designee will be responsible for completion of the audits. 5. The QA committee will be responsible for review and setting future audits. 6. DON will be responsible for compliance.	

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F 311	Continued From page 10	F 311		

upper lip, chin, and neck. R115 stated, "It was hectic this morning when I got up," and stated he hadn't been offered to shave.

During interview on 7/20/17, at 9:54 a.m. nursing assistant (NA)-D stated she assisted R115 when he got up, and stated he needed help with most cares. NA-D stated R115 asks when he wanted to be shaved, usually on his bath day. NA-D stated, "I don't think I actually asked him today if he wanted to shave."

During interview on 7/20/17, at 11:18 a.m. registered nurse (RN)-A stated she would expect staff to shave residents with cares, however, residents that are in the facility for rehab "should be encouraged to do things for themselves." RN-A stated she would expect R115 to "make his needs known to us." RN-A was unsure if R115 had a razor of his own or if he needed staff assistance to shave. RN-A stated residents that were in the Transitional Care Unit were to be encouraged to do things on their own, because they were transitioning to go home, and the facility wanted "to give them the tools they need when they go home."

During an interview on 7/20/17, at 3:04 p.m. director of nursing (DON) stated, "If a resident wants to shave everyday, we need to make a shaver available or have family bring one in, especially if he wants to be clean shaven. It should be offered."

A facility document entitled Cares AM (morning) and HS (evening), reviewed 9/15, directed "Every resident is to have AM and HS cares done daily." The policy specifically directed "Shave resident's in am (morning) and apply makeup to female

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

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F 311	Continued From page 11 guests as requested."	F 311		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with grooming for facial hair and nail care for 2 of 3 residents (R20, R26) reviewed for activities of daily living (ADLs) who needed extensive assistance. Findings include: R20's annual Minimum Data Set (MDS), dated 5/19/17, indicated R20 was cognitively intact and required extensive assistance of one staff for personal hygiene cares. R20's ADLs Care Area Assessment (CAA), dated 5/24/17, identified diagnoses of anxiety, depression, and "hypoparathyroidism Alzheimer's (sic)." R20 was alert and oriented with some confusion. R20 needed assistance with all activities of daily living (ADL's) R20's care plan, dated 5/24/17, indicated an activity of daily living self-care performance deficit. R20 required assistance of one staff for personal hygiene cares. The Tasks section in R20's electronic medical record indicated R20 received a bath on 7/10/17,	F 312	Corrective Action: Resident 20, 26 had facial hair removed and nail care provided. Policy and procedure reviewed and current. Corrective Action as it applies to other residents: All residents were reviewed as to whom needs assistance with shaving and nail care. Staff was educated at an In Service during the week of 8/21/2017 and ongoing regarding policy for shaving and nail care. Residents preferences for grooming will be honored as requested. Facility will make tools available to staff and residents. Corrective Action will be monitored by: Audits done weekly for 10% of randomly chosen residents. Shaving and nail care will be checked at this time. Shaving and nail care will be monitored as well on non bath days to ensure resident are shaved and have nails groomed to their preference. All residents are reviewed for their	8/29/17

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F 312	Continued From page 12 7/13/17 and 7/17/17. R20 had no refusal of cares. During observation and interview with R20 on 7/18/17, at 9:34 a.m. R20 was observed to have several long, curled hairs on the chin and above the lip. R20 stated she would like the hairs removed, but staff do not allow her to have a tweezers. During observation and interview with R20 on 7/19/17, at 9:02 a.m. R20 continued to have several long, curled hairs on the chin and above the lip. R20 stated "I need that taken care of." R20 stated she could not recall the last time someone helped in removing the facial hair. During observations on 7/20/17, at 8:20 a.m. nursing assistant (NA)-B was observed pushing R20 in a wheelchair out of the tub room and into the dining room. R20 continued to have several long, curled hairs on the chin and above the lip. During interview on 7/20/17, at 9:19 a.m. NA-B stated she assisted R20 with a tub bath prior to breakfast. NA-B stated R20 needed assistance with personal cares and did not refuse cares. NA-B stated during the bath, she asked R20 if she wanted the facial hairs shaved and the resident requested to wait until after breakfast. During an interview on 7/20/17, at 9:25 a.m. licensed practical nurse (LPN)-D stated due to a history of over plucking causing facial sores, R20 was not allowed to use a tweezers. R20 needed staff assistance to shave. LPN-D stated R20 was able to ask for assistance and would usually tell staff when she wanted the facial hair removed. LPN-D observed R20's facial hair and stated the hair was long.	F 312	preferences and ADL choices on admission, during quarterly care conferences, annual assessments and with a change in condition. Compliance: 1. The DON or designee will be responsible for completion of the audits. 2. The QA committee will be responsible for review and setting future audits. 3. DON will be responsible for compliance.	

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F 312	Continued From page 13	F 312		

R26's significant change ADLs CAA, dated 11/1/16, identified a diagnosis of dementia and had been placed on hospice. The CAA noted R26 was able to be understood and was able to understand staff, had verbal behaviors related to yelling out, and needed extensive assistance with personal hygiene. The CAA did not indicate R26 rejected cares.

R26's quarterly MDS, dated 4/28/17, indicated a severe cognitive impairment and needed extensive assistance of one staff to complete personal hygiene. The MDS further indicated R26 did not display rejection of cares behaviors during the assessment period.

R26's care plan, revised on 11/7/16, identified a deficit in ADL self care related to advancing dementia, behaviors, pain, and depression. The care plan goal indicated R26 was to improve current level of participation in grooming, and specifically directed "I require 1 staff participation with personal hygiene and oral care."

During observation on 7/18/17, at 8:57 a.m. R26 was observed sitting in her wheelchair; short white hairs were observed on R26's chin, with long white hairs observed in the corners of her upper mouth by her lip. At that same time, a white and pink electric razor was observed resting on the right side of R26's bathroom sink. R26 was observed with thick long rounded fingernails, which appeared discolored with a yellow brown hue.

During interview on 7/18/17, at 9:58 a.m. family member (FM)-A stated R26's nails were "Terrible!", and had asked staff to clip them every week. FM-A reported R26's nails were shorter

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LAKE MINNETONKA SHORES	4527 SHORELINE DRIVE SPRING PARK, MN 55384

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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now than they had been; however, "You can't just put polish on two inch nails," and further reported it was a concern because R26 ate with her fingers a lot. FM-A had noticed the facial hair the past couple of weeks, and stated there used to a be a staff member who would consistently shave it.

During observation on 7/19/17, at 7:06 a.m. R26 was up in her wheelchair; her morning cares had been completed. R26's nails were long but now covered with pink nail polish. R26 was observed with the same short white chin hairs and the same longer white hairs curling around the sides of her mouth. The white and pink razor continued to sit on the right side of R26's bathroom sink.

During interview on 7/19/17, at 7:27 a.m. (LPN)-B stated nail care and shaving were completed on bath days. LPN-B noted R26 was scheduled for two evening baths a week, and had just had one on Monday. LPN-B stated the nurses completed Body Audits on bath days which included checking for long unclean nails and facial hair. LPN-B reported refusals would be documented on the body audits, and if re-approached later, she would put in a general progress note that the cares were re-attempted. LPN-B further stated some residents had nail care on their treatment record (TAR) to at least assess the length of the nails. LPN-B reported R26 ate with her fingers at times, and while observing R26's nails stated "If I had done her Body Audit, I would have trimmed them." LPN-B verified R26 had facial hair, noting it did not appear she was shaved on her bath day; LPN-B stated they tried to check female residents daily for facial hair.

During interview on 7/19/17, at 1:36 p.m. NA-C

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stated she had completed R26's cares that morning, and R26 needed assistance with her personal hygiene. NA-C stated if R26 wanted to shave, then they would shave her, but further stated she had not offered to shave R26 with morning cares. NA-C reported R26 "doesn't really refuse" shaving, "You have to let her know you are going to shave, then [R26] will say yes." NA-C stated she would clean underneath the nails, but not trim them, and thought activities did the nail care stating "they do their nails and paint them." NA-C reported they did not document nail care or shaving, but would tell the nurse if R26 refused. NA-C verified the pink and white shaver was R26's personal shaver kept in her bathroom.

During interview on 7/20/17, at 1:26 p.m. registered nurse (RN)-C stated R26 needed assistance with personal cares, and could be really resistive to cares too, stating R26 had refused shaving earlier that week. RN-C stated R26's family was aware of her refusals and would talk about it in care conferences. RN-C stated they re-approached R26 when she refused or would call one of her daughters. RN-C reported shaving was done "on bath days for sure" and as needed with morning cares, which varied depending on the resident. RN-C further reported nail care was done on bath days along with manicures from the activity staff, further noting R26 would refuse nail care. RN-C stated in the past family had concerns regarding R26's nails, and were able to trim them with family present. RN-C stated R26's nails "were never super short," and reported she had tried to trim them in the past and R26 refused.

During interview on 7/20/17, at 2:20 p.m. the director of nursing (DON) stated shaving was

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F 312	Continued From page 16 always individualized to the resident, but should be done a a minimum for women once a week with their bath. The DON further stated residents were to be shaved when they visualized facial hair, and if a resident was not receptive, then there should be documentation of refusals. The DON reported there were many female residents who wanted only certain people to manicure their nails; however, nail care was done on bath days and nails were kept at a "respectable length and according to what [residents] liked." Review of the 2nd Floor Bath List and Body Audits identified R26 received two baths a week, and had baths on 7/14/17 and 7/17/17. There were no refusals or cares documented. A facility policy entitled Cares AM (morning) and HS (evening), reviewed 9/15, directed "Every resident is to have AM and HS cares done daily." The policy specifically directed "Shave resident's in am (morning) and apply makeup to female guests as requested." The policy did not address nail care.	F 312		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		8/29/17

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F 329	Continued From page 17 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure resident specific target behaviors for anti-psychotic medications were monitored for 1 or 5 residents (R183) reviewed for unnecessary medications. Findings include: R183's admission Minimum Data Set (MDS), dated 6/21/17, indicated a severe cognitive impairment, diagnoses of Alzheimer's disease,	F 329	Corrective Action: Resident R 183 s care plan was updated and the target behaviors adjusted to include monitoring for delusions and hallucinations. Physician was contacted regarding the need for medication at continuing dose. Policy and procedure reviewed and updated. Staff was educated at an In Service regarding policy for Psychoactive Medication and Unnecessary Medication Use Policy for reporting and recording	

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F 329	Continued From page 18 anxiety, and depression. The MDS also identified R183 took psychotropic medications including an anti-psychotic, and had experienced delusions (misconceptions or beliefs that are firmly held, contrary to reality) during the assessment period. R183's admission psychotropic Care Area Assessment (CAA), dated 6/21/17, identified a diagnosis of Alzheimer's disease with behavioral disturbance, and was prescribed Seroquel (anti-psychotic medication). The CAA listed the care planning goal to "avoid complications" and indicated side effects of the psychotropic medication would be monitored; it did not address any target behaviors for the use of Seroquel. R183's Psychoactive Drug assessment, dated 6/20/17, indicated she took Seroquel related to hallucinations and delusions with target behaviors of "agitation/seeing things that are not there/thinking people are there to do her harm." A facility progress note, dated 6/20/17, at 10:18 a.m. indicated R183 had delusional thinking. The note identified, while watching the television, R183 verbalized the people on television were coming to get her and her things. In addition, it was noted R183 had delusions the housekeeping staff had taken a woman into her bathroom. There were no other notes charted regarding R183's delusions. R183's Point of Care (POC) Behavior monitoring, from 6/21/17 to 7/19/17 directed staff to observed for the following behaviors: "physical behavioral symptoms directed toward others (e.g. hitting, kicking, pushing, scratching, grabbing, abusing others sexually).", "verbal behavioral symptoms directed toward others (e.g. threatening others,	F 329	target behaviors. Corrective Action as it applies to other residents: A review of all residents on psychotropic medication for proper diagnosis for use of the medication. The care plans were audited for addressing the use of the medication including target behaviors the drug is used for. The charts will be audited to make sure the charting regarding the psychotropic are in place. In-service for staff the week of 8/21/2017 and ongoing. All residents are reviewed on admission, during quarterly care conferences, annual assessments and with a change in condition as part of the RAI process. Corrective Action will be monitored by: Audits done weekly for 10% of randomly chosen residents who have psychotropic drugs in their plan of care. Audits will include correct diagnosis, care plan is current and Target behaviors are listed and charted on in PCC. Compliance: 1. The DON or designee will be responsible for completion of the audits. 2. The QA committee will be responsible for review and setting future audits. 3. DON will be responsible for compliance.	

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screaming at others, cursing at others).", and "behavioral symptoms not directed at others (e.g. physical symptoms such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like screaming, disruptive sounds)." The monitoring did not address R183's delusions and/or hallucinations.

R183's current care plan, dated 6/29/17, noted anti-psychotic use due to dementia with behavioral disturbance. Interventions for R183 included to administer medications, educate on the risks and benefits of psychotropic use, monitor for side effects of the anti-psychotic, and "monitor/document for side effects and target behaviors," however, the care plan did not include resident specific target behaviors that were to be monitored.

A Consultant Pharmacist Communication, dated 7/10/17, recommend starting a gradual dose reduction (GDR) for R183's Seroquel, due to "There is no documentation of delusions or other behavior concerns." The next day, on 7/11/17, R183's physician signed the recommendation with an order to decrease the Seroquel to 12.5 mg (milligrams) bid (twice a day).

During observation on 7/20/17, at 8:23 a.m. R183 was observed in the dining room eating breakfast. R183 had a coffee cup and bowl of oatmeal in front of her. R183 was observed talking to her oatmeal saying it was the best oatmeal and the best coffee, then looking up and repetitively asking the two female residents sitting at the next table "didn't you get some it's very very good." Later that morning, at 9:01 a.m. trained

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medication aide (TMA)-A went into the dining room to administer R183's oral medications. R183 began to tell TMA-A she needed to go home, and while taking the pills stated R183 stated "You better watch, they are watching us," and refused to take the last pills because she was being watched. TMA-A stated "Okay, I will make sure no one is watching us," and positioned herself in R183's line of site. R183 took her last pills but continued to say "They are watching us."

During interview on 7/20/17, at 9:24 a.m. TMA-A stated R183 could be wild at times, and was better at taking medications outside of her room then in her room, because she says people are watching her. TMA-A reported R183 said this often and "most of the time she is in her own world," and would tell people "don't look at me," and would see things that aren't there, like her family or children. TMA-A further stated R183 would talk to her meal, having discussions with it "forever" before she ate it. TMA-A reported R183's delusions did not upset her, and was able to be re-directed. TMA-A reported when R183 had these behaviors, she would tell the nurse or direct a nursing assistant to record it.

During interview on 7/20/17, at 10:10 a.m. licensed practical nurse (LPN)-C stated R183 had some delusions such as looking for babies and talking about things that didn't make sense. LPN-C reported R183 would call out "baby, baby, oh thank you baby." LPN-C stated there was monitoring in the computer for behaviors with cares, monthly monitored target behaviors for a period of time, and charted the monitoring in the progress notes, however, LPN-C was unable to find R183's target behaviors and stated, "as of now there are none."

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During interview on 7/20/17, at 10:39 a.m. registered nurse (RN)-D stated R183 had transferred from a different unit, was still "getting to know her," further stating her care plan and target behavior monitoring was still in progress. RN-D stated nursing assistants documented behaviors in the point of care (POC) on the computer and the nurses would document behaviors under the treatment record (TAR), further stating if behaviors are noted the medication would be looked at for effectiveness. RN-D acknowledged with the reduction of R183's Seroquel, behavior monitoring would be important in order to evaluate the reduction's effectiveness. RN-D reported when a reduction is started, a one week assessment was initiated for target behaviors to evaluate effectiveness of the reduction. RN-D stated the nurse who initiated the decrease failed to set up the assessment at that point, and would need to follow up with it.

During interview on 7/20/17, at 2:11 p.m. the director of nursing (DON) stated psychotropic medications are identified with the appropriate diagnosis and need for reduction by the first MDS. The DON further stated residents should have behaviors for the diagnosis of the anti-psychotic, along with approaches related to what the target behaviors are.

The facility's Psychoactive Medication and Unnecessary Medication Use Policy, reviewed 11/16, directed "Specific target behaviors will be monitored for psychoactive medications." It further directed the care plan would include those specific target behaviors, and designated staff would document behaviors and the effectiveness of the medication.

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F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		8/29/17

(a) Infection prevention and control program.

The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism

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F 441	Continued From page 23 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement appropriate infection control practices for for 1 of 1 residents (R261) reviewed for isolation precautions. Findings include: R261's Admission Record, dated 7/7/17, indicated R261 had diagnoses including acute respiratory failure, pneumonia due to methicillin resistant staphylococcus aureus (MRSA) (contagious bacterium with antibiotic resistance),	F 441	Corrective Action: A sign was attached to resident door to notify visitors to stop at nurses station for directions before visiting. Policy and procedures for isolation reviewed and current. Corrective Action as it applies to other residents: In-service for staff during the week of 8/21/2017 and ongoing. All staff are trained on hire and minimally yearly on infection control policies and procedures.	

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F 441	Continued From page 24 and chronic obstructive pulmonary disease (lung disease). R261's Order Summary Report, dated 7/20/17, indicated droplet precautions due to MRSA-respiratory. Resident must wear a mask when out of room. Staff should also wear mask, glove and gown. R261's progress note, dated 7/12/17, indicated resident went out with family around dinner and patient brought dinner back to his room. The note went on to indicate resident continues on droplet precautions, coughing still noted and that patient wears mask when out of room. R261's progress note, dated 7/15/17, indicated resident had pizza delivered for dinner. R261's progress note, dated 7/19/17, indicated resident is independent with cares and mobility. Resident continues on droplet precautions. Resident wears a mask when he comes out of room. During observation on 7/18/17, at 1:20 p.m. R261's room was observed to have personal protective equipment (PPE) hanging on the outside of the door in a PPE drape. The equipment included gloves, gowns and masks, however, there was no sign on or near the door that indicated staff or visitors should stop and ask a nurse prior to entering the room. During interview on 7/18/17, at 1:28 p.m. housekeeper (H)-A, stated that the PPE was hanging on the door for protection. H-A stated he was informed by the nurses when the resident was admitted that he must wear gloves, gown	F 441	All resident who are in isolation will have instructions on their door to see the nurse before entering. Correction Action will be monitored by: Audits will be done by Nursing on all residents in isolation. Compliance: 1. The DON or designee will be responsible for completion of the audits. 2. The QA committee will be responsible for review and setting future audits. 3. DON will be responsible for compliance.	

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F 441	Continued From page 25 and mask when entering the room and that he would remove the PPE just before leaving the room. During interview on 7/18/17, at 1:32 p.m. licensed practical nurse (LPN)-A, stated the PPE was on R261's door because he was on droplet precautions and has pneumonia. She stated staff are made aware of the need to wear the PPE as this is passed on to the staff during report. She also stated that everyone that cares for him is aware that they need to wear the PPE before entering the room. LPN-A went on to state that this could be a problem for visitors and that their should be a sign on the door to let them know to stop and see a nurse before entering the room. She stated, "I will take care of that right now. " During interview on 7/18/17, at 1:38 p.m. registered nurse (RN)-A stated staff are made aware of the droplet precautions by the nurse order in the resident record and that housekeeping staff are made aware during report. She stated most of the time visitors would know about the droplet precautions by the PPE hanging on the door but there is a chance they would just walk in the room. RN-A went on to state this had been their procedure, just to hang the PPE equipment on the door, or have a cart next to the door with PPE in the cart. During observation on 7/18/17, at 1:44 p.m. a sign was hanging on R261's door that directed, stop and see nurse before entering. During interview on 7/20/17, at 11:11 a.m. the Director of Nursing (DON) stated when a resident is on isolation precautions there should be a sign on the door that states to, stop and ask at the	F 441		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 26 nurses station. The DON went on to state they typically put up signs any time they have had a contagious disease in the building. She stated it is not very often they have a resident with droplet precautions in our building, but when they do, should have a sign up. The facility's Infection Control Policy, Visitor Guidelines for Transmission Based Precautions, dated 2015, indicated when a resident requires transmission based precautions, a sign will be posted on a resident's door to alert the visitor to check with the charge nurse before entering the room for the first time.	F 441		

F5210025

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	245210	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	07/20/2017

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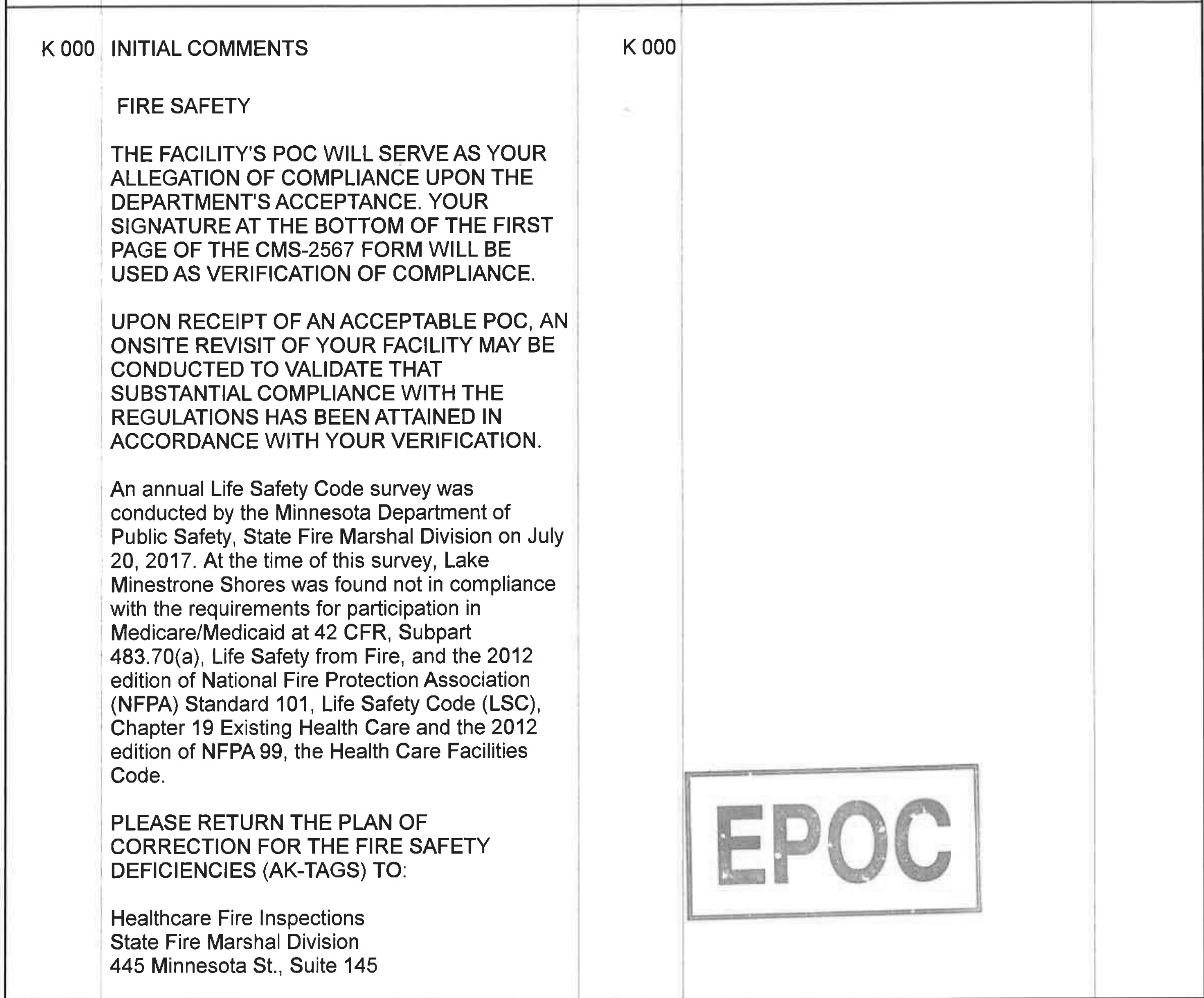
LAKE MINNETONKA SHORES	4527 SHORELINE DRIVE SPRING PARK, MN 55384



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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.

An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on July 20, 2017. At the time of this survey, Lake Minestrone Shores was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (AK-TAGS) TO:

Healthcare Fire Inspections
State Fire Marshal Division
445 Minnesota St., Suite 145

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/18/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245210	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/20/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 St. Paul, MN 55101-5145, OR By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was determined to be of Type II (222) construction. Original construction in 1966 with additions in 1974 & 1982 and was determined to be of Type I (332). It has a partial basement and is fully protected throughout by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridor that is monitored for automatic fire department notification. In June of 2011, a 1-story building was constructed and determined to be of Type II (222) construction. It contains a basement and is attached to the existing nursing home and is separated from an attached assisted living facility by 2-hour fire rated construction. The new addition is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors and is monitored for automatic fire department	K 000		

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	245210	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**07/20/2017**

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

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K 000	Continued From page 2 notification. Because the original construction and additions are built of conforming construction, the facility will be surveyed as one building. The facility has a capacity of 131 beds and had a census of 108 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 200 SS=F	NFPA 101 Means of Egress Requirements - Other Means of Egress Requirements - Other List in the REMARKS section any LSC Section 18.2 and 19.2 Means of Egress requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2 This STANDARD is not met as evidenced by: Based on document review and staff interview determined that there were Means of Egress requirements that were not addressed by the provided AK-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. 18.2, 19.2. This deficient practice could effect all 108 residents. Findings include:	K 200	An annual fire rated door assembly inspection has been conducted as of 8-14-17. All findings will be corrected by 8-28-17. Cory Gerber, the Environmental Services Director is responsible For corrections and monitoring of fire rated door assemblies.	8/29/17

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	245210	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	**07/20/2017**

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

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K 200	Continued From page 3 On a facility tour between the hours of 1000 and 1600 on July 20, 2017, document review and and staff interview revealed that the facility could not provide evidence of an annual fire rated door assembly inspection. This deficient practice was verified by the Maintenance Director at the time of discovery.	K 200		
K 901 SS=F	NFPA 101 Fundamentals - Building System Categories Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and document review, the facility did not implement a risk assessment procedure for building systems designed to meet Category 1 through 4 in accordance with NFPA 99, Chapter 4. This deficient practice could affect all 108 residents. Findings include: On a facility tour between the hours of 1000 and 1600 on July 20, 2017, document review and staff interview revealed that the facility could not provide evidence of having a documented risk assessment.	K 901	A Risk Assessment procedure for building systems designed to meet Category 1-4 in Accordance with NFPA 99 Chapter 4 has been implemented as of 8-8-17. Cory Gerber, Environmental Services Director is responsible for maintaining compliance.	8/29/17

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K 901	Continued From page 4 This deficient practice was verified by the Maintenance Director at the time of discovery.	K 901		
K 923 SS=C	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with	K 923		8/29/17

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

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K 923	Continued From page 5 integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, that facility did not properly store oxygen cylinders in accordance with NFPA 99. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5. This deficient practice could affect all 108 residents. Findings include: On a facility tour between the hours of 1000 and 1600 on July 20, 2017, observation revealed that the oxygen cylinders in the storage rooms were not separated between full and empty cylinders. This deficient practice was verified by the Maintenance Director at the time of discovery.	K 923	Oxygen cylinders have been segregated between full and empty as of 8/14/17. Routine checks will be maintained to ensure compliance. Cory Gerber, Environmental Services Director is responsible for maintaining compliance.	