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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: I3OM

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245210**
2.STATE VENDOR OR MEDICAID NO.
(L2) **172043100**

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

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

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

6. DATE OF SURVEY 09/10/2013 (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

Post Certification Revisit by review of the facility's plan of correction to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective September 3, 2013, the facility is certified for 145 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Sarah Grebenc, Unit Supervisor 12/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/20/13 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00320 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE
09/19/2013 (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

September 20, 2013

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

RE: Project Number S5210022

Dear Mr. Lahammer:

On August 8, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 25, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 10, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard extended survey, completed on July 25, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 3, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 25, 2013, effective September 3, 2013 and therefore remedies outlined in our letter to you dated August 8, 2013, 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.

Sincerely,

Anne Kleppe

Anne Kleppe, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: 612-201-4124 Fax: 651-215-9697

Enclosure
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5210 December 20, 2013

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

Dear Mr. Lahammer:

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

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

Effective September 3, 2013, the above facility is certified for:

145 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Colleen Leach

Colleen B. Leach, Program Specialist
Program Assurance Unit, Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900, St. Paul, MN 55164-0900
Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File

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

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245210	A. Building B. Wing	9/10/2013

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

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **09/03/2013**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/03/2013**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **09/03/2013**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **09/03/2013**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **09/03/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **09/03/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** SG/AK	**Date:** 09/20/2013	**Signature of Surveyor:** 28589	**Date:** 09/10/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/25/2013

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: I3OM

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

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(L1) **245210**
2.STATE VENDOR OR MEDICAID NO.
(L2) **172043100**

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

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

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

6. DATE OF SURVEY **07/25/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

13.Total Certified Beds 145 (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Annette Truebenbach, HFE NEII 09/04/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS
Posted 9/18/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5210

At the time of the July 29, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 3953

August 8, 2013

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

RE: Project Number S5210022

Dear Mr. Lahammer:

On July 29, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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:

Sarah Grebenc
Minnesota Department of Health
3333 Midtown Square, Suite 212
St. Cloud, Minnesota 56301

Telephone: (320) 223-7365

Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 3, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 25, 2013 (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 25, 2014 (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
Division of Compliance Monitoring
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.

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:

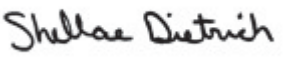
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5210s13.rtf

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 _____	07/25/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225	ok 9/4/13 SG	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lydia Buetow — TITLE: Cave Center Administrator — (X6) DATE: 8/22/13

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 _____	07/25/2013

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 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure immediate notifications of abuse, neglect or mistreatment allegations were made to the administrator and state agency (SA) and failed to ensure thorough investigations were conducted for 1 of 5 residents (R14) reviewed for abuse. Findings include: R14's quarterly Minimum Data Set (MDS) dated 6/17/13, indicted R14 was cognitively intact. A care plan revised on 4/2/13, directed two staff and a mechanical lift to assist R14 to use the toilet. When interviewed on 7/23/13, at 11:16 a.m. R14 expressed concerns of mistreatment by a facility employee. R14 indicated that approximately one month prior, when nursing assistant (NA)-B assisted her with the bedpan during the night shift, NA-B was overheard to state, "That b**ch." R14 added that another staff then entered her	F 225	**F000** **This plan and response to these survey findings is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do not constitute an admission of noncompliance with any requirement nor an agreement with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations.** **F 225/226 Corrective Action:** a. R 14 was re-interviewed by Household Coordinator and a VA report was filed with the MDH on 7/25/2013 relating to incident of 5/20/213. The report of maltreatment was investigated by the facility internally as required by state law and reported to the MDH with in the 5 working days. The findings of	

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F 225	Continued From page 2 room with NA-B to assist with the bedpan. When interviewed on 7/25/13, at 10:11 a.m. licensed practical nurse (LPN)-B explained that if a resident expressed an allegation of abuse, neglect or mistreatment, the resident was brought to the office for an interview. The director of nursing (DON) and administrator were then to be notified of the incident. The staff member involved with the incident was to be removed from the schedule until an investigation was completed. LPN-B verified awareness of the allegation of mistreatment described by R14. LPN-B confirmed the administrator and DON should have been notified of the allegation. When interviewed on 7/25/13, at 10:42 a.m. household coordinator (HC)-D verified awareness of the allegation of mistreatment described by R14. HC-D indicated she, HC-B, and LPN-B placed a phone call to NA-B on 5/21/13 regarding R14's allegation. HC-D explained they interviewed NA-B and HC-B recorded the interviews on a typed document, but no further action was taken. HC-D confirmed she did not interview R14 about the incident. HC-D was unaware of whether the administrator or DON had been notified of the incident with R14 and NA-B. When interviewed on 7/25/13, at 10:59 a.m. HC-B verified R14 had informed her that a staff called her a b**ch in the middle of the night on 5/20/13. HC-B stated NA-B denied calling R14 a b**ch and was not aware of anyone having done so. HC-B also interviewed registered nurse (RN) -B on 5/21/13, and RN-B was not aware of any issues or complaints during the night shift related to R14. HC-B reported that something had been	F 225	investigation were found to be unsubstantiated by the MDH and no further action taken. **Corrective Action as it applies to other Residents:** a. All Household staff meeting will be held during the week of 8/26/2013 to review the Lake Minnetonka VA policy. The VA policy will be reviewed for the definitions of verbal abuse including oral, written or gestured language. In addition the timely of reporting of a suspected incident to the Nursing Home Administrator or designee will be reviewed. The review of LMS policy to include the internal investigation and proper filing of a suspected report of violation to the State Agencies.	

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F 225	Continued From page 3 written up on the incident and was filed in NA-B's employment file. HC-B indicated the next steps would have been to determine whether NA-B should have been taken off the schedule, investigate more and inform the administrator of the incident. HC-B verified nothing had been done past writing up the incident. When interviewed on 7/25/13, at 11:10 a.m. the DON revealed she was not familiar with the allegation and was unable to find an email regarding the incident with R14 and NA-B. The DON stated that staff should have called the administrator or the DON right away regarding this incident. When interviewed on 7/25/13, at 1:16 p.m. the administrator verified she was not aware of the allegation prior to 7/25/13. The administrator confirmed allegations of abuse, neglect or mistreatment were to be investigated, with the investigation including interviews with the resident involved, the staff involved, other employees and other residents. The administrator reported that R14's report was not treated as an abuse allegation and verified it was not reported to the SA. The administrator reported that a new investigation into R14's allegation was initiated on 7/25/13. Review of a typed document dated 5/21/13, by HC-B, indicated the phone interviews with NA-B and RN-B were conducted and reviewed. The facility lacked further documentation related to R14's allegation of mistreatment. The facility's Vulnerable Adult Abuse Prevention Plan revised 4/12, indicated any form of resident abuse, neglect or exploitation would not be	F 225	b. Call Tree initiated to ensure timely action in reporting injury of unknown origin or suspect abuse to the MDH according to the guidelines set forward. **Date of Completion:** 9/3/2013 **Reoccurrence will be prevented by:** a. The reoccurrence will be prevented by completion of the VA report to Nursing Home Administrator and follow up internal investigation. The investigation files will be submitted to the Nursing Home Administrator or Clinical Administrator for review.	

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F 225	Continued From page 4 tolerated. The plan defined verbal abuse as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents or within their hearing distance. The plan detailed that all cases of mistreatment were to be reported immediately to an employee's supervisor who was then responsible to report it immediately to the administrator. The plan instructed the administrator to appoint a staff person to conduct an internal investigation of the allegation. Review of Internal Investigative Steps dated 4/12, directed staff to immediately make a report to the SA. The investigative guide also instructed an initial report of the investigation to include the nature and extent of the alleged mistreatment, any evidence of previous mistreatment and any other information the reported believed might be helpful in further investigation of the mistreatment.	F 225	**The correction will be monitored by:** a. Nursing Home Administrator or designee will monitor the investigations to ensure that reports are complete including notification documentation of the Administrator and information is passed to the CEP. Resident interviews will be completed weekly for four weeks with 5% of residents.	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement the abuse prohibition policy related to notification of administrator, notification to the state agency (SA) and thorough investigations, for 1 of 5 residents (R14)	F 226	a. Nursing Home Administrator and the Clinical Administrator will be responsible for compliance.	

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F 226	Continued From page 5 reviewed for abuse. Findings include: The facility's Vulnerable Adult Abuse Prevention Plan revised 4/12, indicated any form of resident abuse, neglect or exploitation would not be tolerated. The plan defined verbal abuse as the use of oral, written or gestured language that willfully included disparaging and derogatory terms to residents or within their hearing distance. The plan detailed that all cases of mistreatment were to be reported immediately to an employee's supervisor who was then responsible to report it immediately to the administrator. The plan instructed the administrator to appoint a staff person to conduct an internal investigation of the allegation. Review of Internal Investigative Steps dated 4/12, directed staff to immediately make a report to the SA. The investigative guide also instructed an initial report of the investigation to include the nature and extent of the alleged mistreatment, any evidence of previous mistreatment and any other information the reported believed might be helpful in further investigation of the mistreatment. R14's quarterly Minimum Data Set (MDS) dated 6/17/13, indicted R14 was cognitively intact. A care plan revised on 4/2/13, directed two staff and a mechanical lift to assist R14 to use the toilet. When interviewed on 7/23/13, at 11:16 a.m. R14 expressed concerns of mistreatment by a facility employee. R14 indicated that approximately one month prior, when nursing assistant (NA)-B	F 226		

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F 226	Continued From page 6 assisted her with the bedpan during the night shift, NA-B was overheard to state, "That b**ch." R14 added that another staff then entered her room with NA-B to assist with the bedpan. When interviewed on 7/25/13, at 10:11 a.m. licensed practical nurse (LPN)-B explained that if a resident expressed an allegation of abuse, neglect or mistreatment, the resident was brought to the office for an interview. The director of nursing (DON) and administrator were then to be notified of the incident. The staff member involved with the incident was to be removed from the schedule until an investigation was completed. LPN-B verified awareness of the allegation of mistreatment described by R14. LPN-B confirmed the administrator and DON should have been notified of the allegation. When interviewed on 7/25/13, at 10:42 a.m. household coordinator (HC)-D verified awareness of the allegation of mistreatment described by R14. HC-D indicated she, HC-B, and LPN-B placed a phone call to NA-B on 5/21/13 regarding R14's allegation. HC-D explained they interviewed NA-B and HC-B recorded the interviews on a typed document, but no further action was taken. HC-D confirmed she did not interview R14 about the incident. HC-D was unaware of whether the administrator or DON had been notified of the incident with R14 and NA-B. When interviewed on 7/25/13, at 10:59 a.m. HC-B verified R14 had informed her that a staff called her a b**ch in the middle of the night on 5/20/13. HC-B stated NA-B denied calling R14 a b**ch and was not aware of anyone having done so. HC-B also interviewed registered nurse (RN)	F 226		

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F 226	Continued From page 7 -B on 5/21/13 and RN-B was not aware of any issues or complaints during the night shift related to R14. HC-B reported that something had been written up on the incident and was filed in NA-B's employment file. HC-B indicated the next steps would have been to determine whether NA-B should have been taken off the schedule, investigate more and inform the administrator of the incident. HC-B verified nothing had been done past writing up the incident. When interviewed on 7/25/13, at 11:10 a.m. the DON revealed she was not familiar with the allegation and was unable to find an email regarding the incident with R14 and NA-B. The DON stated that staff should have called the administrator or the DON right away regarding this incident. When interviewed on 7/25/13, at 1:16 p.m. the administrator verified she was not aware of the allegation prior to 7/25/13. The administrator confirmed allegations of abuse, neglect or mistreatment were to be investigated, with the investigation including interviews with the resident involved, the staff involved, other employees and other residents. The administrator reported that R14's report was not treated as an abuse allegation and verified it was not reported to the SA. The administrator reported that a new investigation into R14's allegation was initiated on 7/25/13. Review of a typed document dated 5/21/13, by HC-B, indicated the phone interviews with NA-B and RN-B were conducted and reviewed. The facility lacked further documentation related to R14's allegation of mistreatment.	F 226		

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F 323	Continued From page 8	F 323		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure each resident's environment remained free of accident hazards and each resident received adequate assessment for assistive devices related to a bed side rail for 1 of 3 residents (R116) reviewed for accidents. Findings include: During an observation and family interview on 7/23/13, at 10:29 a.m. R116 was observed in bed with a single, middle, quarter sized side rail along the center of the right side of her bed. Family-A stated the family had placed this rail on R116's bed and indicated the facility was aware of this action. Bilateral grab bars were also noted, next to the head of R116's bed. During an observation on 7/24/13, at 12:30 p.m. the side rail was noted as a half inch diameter, single metal rail wrapped with white tape. The side rail was unsecured from the bed frame, with a perpendicular surface extending between the box spring and mattress, which held the side rail in place. Open spaces in the side rail measured six and one quarter inches horizontally, from the top of the mattress to the bottom of the metal bar,	F 323	**F323 Corrective Action:** a. The bedrail was assessed and removed from the bed of R116 on 7/24/2013. **Corrective Action as it applies to other residents:** a. All staff in-service scheduled for the week of 8/26/2013. At the in-service the FDA guidelines will be presented for side rails and proper placement of physical devices on beds. Staff will be instructed to notify their immediate supervisor of devices attached to the bed. Physical Device Policy was reviewed and is current and will be reviewed with all house hold staff.	

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F 323	Continued From page 9 with the bar being approximately two feet in length. When interviewed on 7/24/13, at 12:52 p.m. nursing assistant (NA)-A reported R116 did at times shift down when in bed, toward the foot of the bed. NA-A denied having previously known the middle side rail was on R116's bed or who had placed it there. When interviewed on 7/24/13, at 1:00 p.m. trained medication aide (TMA)-A verified she provided medications to R116 while she was in her bed. TMA-A denied any specific knowledge of R116's side rails. When interviewed on 7/24/13, at 1:10 p.m. licensed practical nurse (LPN)-A stated the additional side rail may have been placed after a fall per therapy or per R116's family. LPN-A indicated maintenance likely placed the side rail on R116's bed. LPN-A denied concerns with the side rail and stated she would report to the registered nurse (RN) if R116 was observed close to the rail or was thought to have a risk of becoming entrapped. When interviewed on 7/24/13, at 1:16 p.m. RN-A stated she believed R116 had only bilateral grab bars and no side rail. Once verified by observation of the room, RN-A confirmed an additional, middle side rail was present on R116's bed. RN-A denied R116 had experienced injuries from use of the side rail. RN-A stated the most recent resident assessment was completed approximately one month prior, during which RN-A denied having noticed the placement of a side rail on R116's bed. RN-A further stated it was expected that NAs, TMAs, LPNs or any staff	F 323	b. An environmental walk though for all rooms schedule for week of 8/26/2013 to ensure there are no other remaining rails which do not match FDA guidelines. **Date of Completion:** 9/3/2013 **Reoccurrence will be prevented by:** a. Environmental Audits will be conducted monthly by Household Coordinator or designee. These audits will be given to Nursing Home Administrator/Clinical Administrator for review. **The Correction will be monitored by:** a. Environmental Audits will be given to Nursing Home Administrator/Clinical Administrator for review.	

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F 323	Continued From page 10 who observed a new side rail, report it to the RN, who would then assess whether the side rail was appropriate and safe to be used for the resident involved. When interviewed on 7/24/13, at 2:10 p.m. director of nursing (DON) stated there had previously been a longer side rail placed on R116's bed that the facility consequently returned to the family. DON reported that R116 currently had only bilateral grab bars and no side rail. Once verified by observation of the room, DON confirmed an additional, middle side rail was present on R116's bed. DON reported she did not believe the side rail was from the facility, but needed to check with maintenance to be sure. DON indicated R116's family may have brought the side rail into the facility and placed it on the bed without facility staff involvement. She confirmed it was her expectation that NAs, TMAs, LPNs, RNs or any staff who observed a new side rail, report the finding to the RN, who was responsible for assessing the device for safety. DON confirmed an assessment for safe use of the side rail noted on R116's bed had not been completed. Review of Physical Device Data Collection Tool dated 1/4/13, identified R116 had a quarter side rail on the left side of her bed and grab bars. When interviewed on 7/24/13, at 3:19 p.m. DON and RN-A confirmed the side rail was documented on the Physical Device Data Collection Tool on 1/4/13, by LPN-A. DON stated a safety assessment of the rail was completed on this date and was subsequently removed as it was deemed to not fit within the facility guidelines for acceptable side rails, R116 was not utilizing	F 323	b. Clinical Administrator will report audits to the QA Team. QA will determine frequency of audits. c. Clinical Administrator will be responsible for compliance.	

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F 323	Continued From page 11 the side rail for any purpose and R116 did not require the use of a side rail. Review of Physical Device Policy modified 1/10, noted, "Upon admission, with significant change and annually, a Physical Device Data Collection Tool is complete. The Physical Device Data Collection Tool will be reviewed quarterly. With changes in a resident's physical device, a new physical device assessment tool will be completed."	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community	F 356	**F356 Corrective Action:** a. Hours for nursing staff will be posted according to guidelines set forward by Health and Human Services and MDH. The proper requirements were added to the Nursing Hours Posting to include the facility name, date and the number of licensed personal and total hours worked. b. The staffing information posting area was moved to the main entrance of LMS TCU. c. All Nursing Staff and Staffing personal will be in-serviced during the	

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F 356	Continued From page 12 standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the nursing hours posting included all required components. This had the potential to effect 138 of 138 residents who resided in the facility. Findings include: During the initial tour observation on 7/22/13, at 1:30 p.m. the facility's nurse staffing information was noted to be posted on the door of the first floor nurse's station. The posting lacked identification of day, evening and night shift times. The posting also lacked separation of the number of staff and total staff hours for partial shifts. In addition, the posting lacked the facility's name. Review of the Report of Nursing Staff Directly Responsible for Resident Care forms (posted nurse staffing information) for 7/23/13, 7/24/13 and 7/25/13 also lacked identification of shift times, separation of partial shifts and the facility's name. In addition, the posting for 7/25/13 was incomplete, lacking the number of licensed practical nurses (LPNs), the total hours for LPNs and the total hours for nursing assistants (NAs). During an interview on 7/25/13, at 3:05 p.m. staffing coordinator (SC) verified she was not familiar with the regulation requirements related to the posted nurse staffing information. She reported she simply filled in the information that was prompted on the facility's Report of Nursing Staff Directly Responsible for Resident Care	F 356	week of 8/26/2013 regarding the requirement. **Date of Completion:** 9/3/2013 **Reoccurrence will be prevented by:** a. The Staffing Coordinator will post the nursing hours for the day. The Nurse in charge of the building for each shift will be responsible to ensure the information is accurate, properly posted and in the proper location. This person will be in charge of updating the information at the start of each shift. b. Random audits will be completed by the Clinical Administrator or designee one time a week to ensure the compliance of this regulation.	

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(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 356	Continued From page 13 form. SC verified the facility name, specified shift times and separated partial shift information was lacking in the facility's current nurse staffing information posting process. SC verified the posting for 7/25/13, lacked complete LPN and NA information. SC reported that she left the sections of the form blank because she was unsure of what changes were going to be made to the schedule. Review of the facility's Nursing Hours Posted policy modified 7/10, indicated the posting was to include the facility name, the date and the total number of hours worked by direct care nursing staff. The policy noted, "The nursing staffing hours will be updated by the staffing personnel to include the actual hours worked by direct nursing staffing."	F 356	**The Correction will be monitored by:** a. The Clinical Administrator will be responsible for compliance. The Clinical Administrator will present audits to QA Committee. b. QA Committee will be responsible for frequency of audits.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper food handling practices during dining service, with the potential to effect 28 of 28 residents who ate in	F 371	**F 371 Corrective Action:** a. Dietary and Nursing Staff were corrected immediately regarding proper food handling practices during dining service.	

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 _____	07/25/2013

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 371	Continued From page 14 the first floor dining room. Findings include: During observations of the breakfast meal on 7/24/13, at 8:10 a.m. dietary aide (DA)-A was noted to prepare food service for the residents in the first floor dining area. With gloved hands, DA-A handled the cupboard doors of the kitchenette to retrieve an individual cereal box, opened the box and plastic bag inside and poured the cereal into a bowl. DA-A then handled the refrigerator door and retrieved a plastic container of strawberries. Then using the same gloved hands, DA-A handled the strawberries to cut off the stems and sliced the strawberries into the cereal bowl, and then removed the gloves and washed his hands. DA-A donned new gloves and again handled the cupboard doors of the kitchenette to retrieve an individual box of cereal. DA-A opened the plastic cereal bag and poured the cereal into the bowl. With the same gloved hands, he handled a half piece of toast in each hand, placed them on a plate and set the plate on the counter to be served to a resident. DA-A then handled the freezer door, opened a bag containing French toast, handled a piece of French toast in each gloved hand and placed them on a plate. DA-A was noted to handle the microwave door and pushed buttons to start the microwave before he removed his gloves and washed his hands. During an interview on 7/24/13, at 11:45 a.m. DA-A stated he changed his gloves any time he touched anything other than food. He explained, "So after touching the fridge or microwave, I change my gloves before going back to serve food." DA-A verified he touched the cupboard doors, refrigerator and freezer handles prior to handling food, without changing gloves and	F 371	**Corrective Action as applies to other residents:** a. In-service will be presented to Dietary Staff and Nursing Staff regarding the issues of proper food handling practices during the week of 8/26/2013. Dietary Assistants are to be changing gloves during food service when touching common area surface. There will be a review of facility's Bare Hand Contact with Ready to Eat Foods. Nursing staff assisting with feeding a resident are not to have contact with finger foods unless there is a barrier to the food being fed. b. Products have been made available to direct care nursing staff to handle finger foods to resident who need eating assistance.	

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 _____	07/25/2013

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 371	Continued From page 15 washing his hands during the morning meal. DA-A stated, "I should probably change my gloves before touching the food." During interview on 7/25/13, at 1:22 p.m. dietary manager (DM) verified it was her expectation for DAs to change gloves after handling the kitchenette cupboards, refrigerator, or any common area surface. Review of the facility's Bare Hand Contact with Ready to Eat Foods created 5/11/10, noted, "Wash hands between any cross contamination during your meal preparations place gloves on clean hands, change gloves often, and remove gloves when contaminated and rewash your hands and put new gloves on."	F 371	**Date of Completion:** 9/3/2013 **Reoccurrence will be prevented by:** a. Audits 2 times per week by Nursing and/or Dietary designee during dining service to ensure compliance with proper food handling techniques. b. Continue to offer principles of infection control through in services annually. c. Audits will be given to Dietary Manager and Clinical Administrator for review. The audits will be presented to the QA Committee. **The correction will be monitored by:** a. Audits will be given to the Clinical Administrator and Dietary Manager f or review at QA meeting for compliance.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431		

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 _____	07/25/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 16 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication storage units were free of expired medications, related to two expired stock medications, with the potential to effect 28 of 28 residents who received medications from the third floor, Southeast medication cart; and for 1 of 1 resident (R277) who received expired medicated eye drops. Findings include: During medication storage observation of the third floor, Southeast medication cart on 7/25/13, at 10:10 a.m. one box containing a Major brand fleets enema (liquid inserted into the rectum as a treatment for constipation) was noted with an expiration date of 6/13. One box containing Lipacol brand lozenges (used to soothe a sore throat) was also noted with an expiration date of 4/13. These expired, stock medications were stored in the medication cart, ready for use.	F 431	b. QA Committee will set further audits after review. c. Dietary Manager and Clinical Administrator will be responsible for compliance. **F431 Corrective Action** a. Outdated stock medication for 3rd South East and 1st medication carts were removed immediately. b. All facility medication storage areas were reviewed and there were no further findings of expired medication.	

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 _____	07/25/2013

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 17 During an interview on 7/25/13, at 10:12 a.m. licensed practical nurse (LPN)-D verified the medications were expired and should have been removed from the cart. During observation of the first floor/yellow dot medication cart on 7/25/13, at 1:10 p.m. revealed R277's Blephamide eye drops (used to prevent or treat eye infections and swelling around the eye) had an expiration date of 5/13. The eye drops were dated as opened/started on 7/11/13. Review of the box instructions on the Blephamide eye drops read, "Blephamide Sus Op [ophthalmic suspension] instill 1 [one] drop into each eye daily." Review of the medication administration record dated 7/13, revealed R277 had received the expired Blephamide eye drops on fifteen occasions between 7/11/13 and 7/25/13. During an interview on 7/25/13, at 1:11 p.m. LPN-C verified the eye drops were expired and should not have been used. Review of the facility's undated Medication Storage In the Facility policy, noted expired medications were to be "immediately removed from stock, disposed of according to facility procedures for medication destruction and reordered from the pharmacy if a current order exists."	F 431	**Corrective action as it applies to other residents** a. All facility medications were reviewed and there were no further findings of expired medication. Merwin Pharmacist to report medication distributed by Merwin with an expiration date prior to prescription to pharmacy for review of practices. b. Licensed staff re-educated to section of existing policy from Merwin regarding Expired Medications. (Expiration dates are monitored prior to administration by the nurse preparing the medication). Continued →	

c. Night Shift will complete weekly audits of medication carts. All medications will be reviewed for expiration and removed as necessary. Results will go to the Clinical Coordinator and Clinical Administrator for review.

d. All staff in -service scheduled for week of 8/26/2013 to include existing policy Disposal of Drugs and supplies to clarify and educate licensed staff for compliance of facility standard.

Date of completion: 9/3/2013

Reoccurrence will be prevented by

a. Clinical Administrator or designee will audit medication storage areas weekly for compliance by visually inspecting medication storage areas.

b. Merwin Pharmacy will audit for compliance quarterly with review of med pass and med storage.

The correction will be monitored by:

a. Audits will be given to Clinical Administrator for review.

b. Clinical Administrator will report findings of audits to Quality Assurance team. QA will determine audit frequency.

c. Clinical Administrator will be responsible for compliance.

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 _____	**07/29/2013**

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	INITIAL COMMENTS Surveyor: 28120 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Lake Minnetonka Shores, Building 1, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 3-story building was determined to be of Type I (332) construction. Original construction in 1966 with additions in 1974 & 1982. It has a partial basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in corridors and spaces open to the corridor that is monitored for automatic fire department notification. In June of 2011, a 1-story building was constructed and determined to be of Type II (222) construction. It contains a basement, is attached to the existing nursing home and is fire separated from an attached assisted living facility. The new construction has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, is fully fire sprinkler protected and is monitored for automatic fire department notification. The new construction contains the kitchen, community room and chapel. The facility has a capacity of 145 beds and had a census of 135 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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

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

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 _____	**07/29/2013**

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 1 MET.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245210	A. BUILDING **02 - BLDG TWO** B. WING _____	**07/29/2013**

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

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K 000	INITIAL COMMENTS Surveyor: 28120 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Lake Minnetonka Shores, Building 2, was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18, New Health Care. In June of 2011, this 1-story building was constructed and determined to be of Type II (222) construction. It contains a basement, is attached to the existing nursing home and is fire separated from an attached assisted living facility. The new construction has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, is fully fire sprinkler protected and is monitored for automatic fire department notification. The new construction contains the kitchen, community room and chapel. The facility has a capacity of 145 beds and had a census of 134 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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